

INSTRUCTIONS

The Appendices & Resources (3/31/2017) posted on DDD website has now been updated. You may either choose to 1) print the entire A&R document or 2) keep your current set of Appendices & Resources and print out the specific pages listed below to create a new set.

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2	Acronyms and Abbreviations	Edited	194 – 198	A&R 15 – 19
3	Assistance Directory	Directory edited, QUEST Integration Health Plans added	200	A&R 21 – 22
4	Participant Safeguards	4E and 4F added	(Add after 4D)	A&R 61 & 62
5	Adverse Event Report	5A added, 5B left blank	(Add before 5C)	A&R 64 – 74
7	General Staff Qualification Requirements	7A edited	249	A&R 86 – 87
8	Monitoring Provider Agencies	8A additional pages added	(Add as part of 8A)	A&R 92 – 98
9	Adult Day Health Resource	9B edited. Remove old 9B and 9C.	274-278	A&R 123
12	Case Management Branch Forms	12E and 12H forms updated	307 & 311	A&R 150 & 154
13	I/DD Waiver Services Schedule of Rates	Rates updated	313 – 317	A&R 156 – 168
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SECTION 4
APPENDICES & RESOURCES

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APPENDIX 1

DEFINITIONS

DEFINITIONS

“Abuse” – means actual or imminent physical, psychological abuse or neglect, sexual abuse, financial exploitation, negligent treatment, or maltreatment, as further defined in Hawaii Revised Statutes (HAR) § 346-222.

“Activities of Daily Living” (ADLS) – means activities related to personal care including, but not limited to, bathing, dressing, toileting, transferring, and eating.

“Adjusted Claims” – means that for each adjusted claim, the new allowed amount is listed first with the previous amount paid to the provider subtracted from the new allowed amount. A new net paid amount is then calculated which may result in additional payment to or a recoupment from the provider.

“Adult Foster Home” (AFH) – means a private home certified under Title 11, Chapter 148, Hawaii Administrative Rules (HAR) that provides care and training for a fee on a (24) twenty-four hour basis for one or two adults with DD/ID who are unrelated to the foster family at any point in time.

“Adult Residential Care Home” (ARCH) – means any facility licensed under Title 11, Chapter 100, HAR that provides twenty-four (24) hour living accommodations, for a fee, to adults who are unrelated to the family and who require at least minimal assistance in the activities of daily living, but who do not need the services of an intermediate care facility. It does not include facilities operated by the federal government. There are two types of ARCHs:

- (1) Type I home for five or less residents; and
- (2) Type II home for six or more residents.

“Adverse Event” – means any incident or event that may have quality of care implications for clients, including, but not limited to:

- (1) changes in the participant's condition requiring medical treatment;
- (2) hospitalization of the participant;
- (3) death of the participant;
- (4) all bodily injuries sustained by the participant for which medical treatment (I.e., treatment rendered by a physician, nurse practitioner, ambulance or emergency medical personnel, or emergency room medical staff) and/or follow up is necessary, regardless of cause or severity;
- (5) all reports of abuse and neglect made to DHS-Adult Protective Services (APS) and/or DHS-Child Protective Services (CPS);
- (6) all medication errors and unexpected reactions to drugs or treatment;
- (7) situations where the participant’s whereabouts are unknown; or
- (8) situations where participant’s behavior requires plan of action or intervention.

“Aversive Procedures” – means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include but are not limited to, electric skin shock, liquid spray to one’s

face and strong, non-preferred tastes applied in the mouth. Aversive Procedures are prohibited and shall not be used with DOH-DDD participants.

“Behavior Support Plan” (BSP) – is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

- (1) the steps that will be taken by the members of the person’s team to modify the physical environment;
- (2) what replacement skills should be taught to the client and how to do so;
- (3) the ways in which team members should respond to challenging behaviors, and;
- (4) ways in which team members can decrease the likelihood of challenging behaviors occurring.

BSP is developed based on the results of a Functional Behavior Assessment (FBA) – see definition of FBA.

“Behavioral Support Review Committee” (BSRC) – It is the committee that will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others.

“Benefit Counseling” – means a service that promotes work preparation by examining current disability benefits and assisting the individual and family to understand the impact of increased income on those benefits.

“Case Management Services” – means services defined in HRS § 333F-1 and HAR Title 17, Chapter 1738 including case assessment, case planning, and on-going monitoring and service coordination to persons with developmental and intellectual disabilities.

“Case Manager” (CM) – means DOH-DDD-CMB case manager who provides targeted case management services as defined in HAR Title 17, Chapter 1738.

“Circle of Supports” – means the participants’ family, friends, and other persons identified by the participant as being important to the planning process. The Circle of Supports are defined in the Individualized Service Plan (ISP).

“Claim” – means a legal document submitted to Medicaid or its fiscal agent for payment.

“Case Management Branch” (CMB) – means the organizational entity under DOH-DDD that is responsible for provision of case management services.

“Centers for Medicare & Medicaid Services” (CMS) – means the federal entity authorized to administer and oversee Medicaid programs.

Community Resources Branch (CRB) – means the organizational entity under DOH-DDD that is responsible for identifying, directing and operating a statewide capacity of resource development, administration and management of services and supports for persons with intellectual and developmental disability (I/DD), and support to their families or guardians. CRB is responsible for monitoring all agency providers under the Medicaid I/DD Waiver Program.

“Denied Claims” – means claims that were not paid due to client eligibility, benefit limitations or claim submission reasons. Denied claims are listed in the “Denied Claims” section of the Remittance Advice (RA) with the corresponding denial reason code(s). Denied claims will not be paid or returned to providers. The RA is the only notification of claim denial.

“Designated Representative” – means an individual identified by the circle of supports who is responsible for making decisions for a participant receiving services under the Medicaid I/DD Waiver when the participant is unable to make his or her own decisions and there is no legal guardian or durable power of attorney.

“Developmental Disabilities Domiciliary Home” (DD Dom) – means any facility licensed under Title 11, Chapter 89, HAR that provides twenty-four (24) hour supervision or care for a fee (excluding licensed nursing care) to no more than five (5) adults with intellectual and/or developmental disabilities as defined in Chapter § 333F, H.

“Developmental Disabilities” – means a severe, chronic disability of a person which, as defined in HRS §333F-1:

- (1) is attributable to a mental or physical impairment or combination of mental and physical impairments;
- (2) is manifested before the person attains age twenty-two;
- (3) is likely to continue indefinitely;
- (4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
- (5) reflects the persons' need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

An individual from birth to age nine who has substantial developmental delay or specific congenital or acquired condition may be considered to have a developmental disability without meeting three or more of the criteria described above, if the individual without services and supports, has high probability of meeting those criteria later in life.

“Direct Support Worker” (DSW) – means a staff hired by the provider in accordance with the standards to provide services under the Medicaid I/DD Waiver as specified in the Individual Plan (IP).

“Department of Health, Developmental Disabilities Division” (DOH-DDD) – is responsible for developing, leading, administering, coordinating, monitoring, evaluating, and setting direction for a comprehensive system of supports and services for persons with developmental disabilities or mental retardation in compliance with HRS § 333.

“Extended Care Adult Residential Care Home” (Extended Care ARCH) – means a category of an adult residential care home licensed under HAR Title 11, Chapter 100 that provides twenty-four (24) hour living accommodations, for a fee, to adults unrelated to the family, and that is qualified to serve nursing facility level residents. There are two types of extended care ARCHs:

- (1) Type I home that consists of five or less residents with no more than two nursing facility level residents; and
- (2) Type II home that consists of six or more residents with no more than ten percent of the home's licensed capacity as nursing facility level residents.

“Family Member” – means the biological, adoptive, step, in-law, or “hanai” father, mother, brother, sister, son or daughter, and grandfather or grandmother.

“Financial Literacy” – means a practical financial knowledge to access, save, budget, avoid debt, spend wisely, invest, donate, and manage other aspects of financial decision-making to enhance an individual’s quality of life.

“Functional Behavioral Assessment” or “FBA” – means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Hanai” – is a Hawaiian word which means that a child is permanently given to be reared, educated and loved by individual(s) other than the child’s natural parents at the time of the child’s birth or early childhood. The child is given outright, and the natural parents renounce all claims to the child.

“Individual Plan” (IP) – means a written plan that is developed and implemented by a provider within thirty (30) calendar days of the service start date, which delineates the specific activities that the provider should do to meet the goals and outcomes specified in the Individualized Service Plan (ISP).

“Individualized Service Plan” (ISP) – means the written plan that is required by HRS § 333F-6 and that is developed by the individual, with the input of family, friends, and other persons identified by the individual as being important to the planning process. The ISP shall be a written description of what is important to the person, how any issue of health or safety shall be addressed, and what needs to happen to support the person in the person's desired life.

“Instrumental Activities of Daily Living” (IADLs) – means more complex life activities such as light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, managing one’s medication, and money management.

"Intellectual Disability" – means significantly subaverage general intellectual functioning resulting in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period (HRS § 333F-1).

“Intermittent and Part-Time” – means occurring at irregular intervals, sporadic and not continuous.

“Licensed Practical Nurse” (LPN) – means a person licensed as a practical nurse by the State of Hawaii, pursuant to HRS Chapter 457.

“Licensed Behavior Analyst” (LBA) – is an individual licensed under HRS Chapter 465D.

“Measurable” – means to describe an objective or task in terms that delineate when the participant has accomplished the objective or task. It means it is quantifiable, material, quantitative, assessable, determinable, computable or gauge-able.

Medication Administration Records (MAR) - is a written legal document that provides for the specific documentation of all prescribed medications and supplements that are provided by the waiver worker to a participant during Medicaid Waiver service hours. Refer to the Medicaid Waiver Standards Manual, Section 2.5, Maintenance of Records.

“Medicaid Waiver for Individuals with Intellectual and Developmental Disabilities” (Medicaid I/DD Waiver) – means the home and community based services program authorized under section 1915(c) of the Social Security Act.

“Medicaid Waiver Services” – means the home and community based services that are defined and approved in Hawaii’s Medicaid I/DD Waiver.

“Medical Treatment” – means treatment that is rendered by a physician, physician assistant, nurse practitioner, ambulance or emergency medical personnel, or emergency room medical staff.

“Med-QUEST Division” (MQD) – means a DHS organizational entity that is the state Medicaid agency for the State of Hawaii.

“Moratorium” – means the DDD’s prohibition against a provider providing services to a new Medicaid I/DD Waiver participant.

“Natural Supports” – means supports that are available to the participant within the family, circle of supports, and community and that are unpaid.

“Nursing Delegation Plan” – A plan that identifies the specific nursing tasks that are to be delegated by the Registered Nurse (RN) to the unlicensed direct support worker (DSW) and to provide a specific guideline and signed documentation that training of every DSW has occurred and for every delegable nursing task provided. It is developed for each Participant receiving nursing delegated tasks via Medicaid waiver. Refer to the Medicaid Waiver Standards Manual, Table 1.7-1, Nursing Delegation for specific delegable tasks.

“On-Site Supervision” – means supervision that is provided by a Service Supervisor:

- (1) at the site or location where services are rendered;
- (2) in the presence of the direct support worker (DSW) and the participant receiving services and
- (3) while the participant is receiving services as specified in the IP

“Outcomes and Compliance Branch” – is responsible for the DDD’s quality assurance and improvement program statewide, which include monitoring and evaluating program services, supports, and outcomes for individuals with intellectual disabilities and developmental disabilities (I/DD).

“Paid Claims” – are claims which Medicaid has made payment, and are listed in the “Paid Claims” section of the RA. The allowed amount for each paid claim is listed first followed by any deductions to calculate which may result in additional payment to or a recoupment from provider.

“Participant” – means an individual who meets the Medicaid I/DD Waiver eligibility criteria and who has been admitted into the program. A participant may also be referred to as a "recipient" of Medicaid services and has been determined eligible for DOH-DDD services.

“Person-Centered Planning” – means an on-going process directed by the participant that helps individuals in his or her circle learn how the participant wants to live and describe what supports are needed to help the participant move toward a life considered meaningful and productive.

“Physician” – means a person who is licensed to practice medicine or osteopathy in Hawaii under HRS Chapter 453 or 460.

“Positive Behavior Support” or “PBS” – means a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Support strategies are included in Behavior Support Plans (BSPs).

“Positive Behavioral Support Plan” or “BSP” – means a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

- (1) steps that will be taken by the members of the person’s team to modify the physical environment;
- (2) what replacement skills should be taught to the participant as well as how to do so;
- (3) ways in which team members should respond to challenging behaviors; and
- (4) ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition of FBA).

“Primary Caregiver” – means the caregiver living in the home with the participant who has primary responsibility for the participant’s care and well-being.

“Prior Authorization” (PA) – means a process by which health plans, program contractors, and the Med-QUEST Division determines in advance whether a medical service is appropriate and will be covered for payment. All approved Medicaid waiver services written into the ISP will be authorized by the DOH-DDD-CM. The provider shall receive a prior authorization (PA) notice before the delivery of service.

“Provider Agreement” – means the agreement detailing the conditions for participation in the Medicaid I/DD Waiver that is executed by the authorized representative of the provider and the authorized representative of DHS.

“Provider” – means an agency, company, or individual that has entered into a written Provider Agreement with DHS to provide services under the Medicaid I/DD Waiver to participants as described in the Waiver Standards Manual.

“Readily Available” – means the duration of the on-site monitoring visit or if a desk audit, by the due date.

“Registered Nurse” (RN) – means a person who is licensed as a registered nurse in the State of Hawaii pursuant to Chapter 457, HRS.

“Remittance Advice” (RA) – means a document that accompanies the weekly Medicaid payment to providers and reports all processed claims whether they are paid, denied, pended or in process, as well as all claim adjustments.

“Restraints” – means physical, chemical or mechanical interventions that is used as a last resort on an emergency basis to protect the person from imminent harm to themselves and/or others using the least restrictive means possible and for the shortest duration necessary. Refer to Policy #2.02 on Restrictive Interventions.

1. **“Chemical Restraint”** is a psychotropic medication prescribed by a licensed health care professional with prescriptive authority: 1) on a routine basis without an appropriate Diagnostic

and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or 2) the incidental use of medications, sometimes called PRN or as needed medication, to protect the person from imminent harm to themselves and/or others through temporary sedation or other related pharmacological action. Refer to Policy #2.02 on Restrictive Interventions that are **NOT** considered “Chemical Restraint”.

2. **“Mechanical Restraint”** is an intervention which a device, material or equipment is involuntarily applied to the participant’s body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement and protects him or her from self-harm or harming others. Refer to Policy #2.02 on Restrictive Interventions that are **NOT** considered “Mechanical Restraint”.
3. **“Physical Restraint”** is an intervention in which physical force applied to the person and involuntarily restricts their freedom of movement or normal access to portion or portions of their body. Refer to Policy #2.02 on Restrictive Interventions that are **NOT** considered “Physical Restraint”.

“Restrictive Procedures” or “Restrictive Interventions” – means a practice that limits a person’s freedom of movement, access to other locations, property, individuals or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Satisfactory Skills Verification” – means verification of skills determined by an appropriate Service Supervisor or delegating professional as defined in these standards and special tasks of nursing care, if applicable, to ensure competency in implementing the IP.

“Seclusion” – means restrictive procedure in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. Seclusion is prohibited and shall not be utilized with DOH-DDD participants.

“Service Supervisor” – means an individual identified by the provider who has responsibility for programmatic, administrative, personnel, and contract compliance.

“Sharps Container” – means a rigid, puncture resistant, disposable container with a lid and a prominent biohazard label indicating needle container. The container shall be closable, leak-proof on sides and bottom, easily accessible, and maintained upright throughout use. The container shall be replaced routinely and not allowed to overflow.

“Sharps” or “Sharps Material” – means needles, scalpel blades, skin lancets, bleeding time devices, and any other material that can easily puncture the skin and should be handled with extreme caution.

“Special Task of Nursing Care” or “Special Tasks” – means a procedure that requires nursing education or that requires nursing education and training in order to be performed safely. Refer to HAR Title 16, Chapter 89, Sub chapter 15 (Delegation of Special Tasks of Nursing Care to Unlicensed Assistive Personnel).

“Stabilized in Place” – means the participant has had no further crisis situations, police contact or hospital visits between Crisis Mobile Outreach (CMO) and follow-up call.

“Utilization Review Committee” (URC) – means a DOH-DDD internal committee that reviews cases where approved or utilized services exceed or fall below current use.

“Voided Claims” – means the allowed amount listed as a negative amount and any previous deductions will be added to the allowed amount on the RA. As a result, the net paid amount is the amount to be recouped from the provider.

APPENDIX 2

ACRONYMS & ABBREVIATIONS

ACRONYMS & ABBREVIATIONS

§	Section
ACS	Administrator Certification Section
ADA	American Disabilities Act
ADH	Adult Day Health
ADL	Activity of Daily Living (one)
ADLs	Activities of Daily Living (two or more)
AER	Adverse Event Report
AFH	Adult Foster Home
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
ARCH	Adult Residential Care Home
AT	Assistive Technology
AVRS	Automated Voice Response System
BPQY	Benefits Planning Query
BSP	Behavior Support Plan
BSRC	Behavioral Support Review Committee
CAN	Child Abuse Neglect
CAP	Corrective Action Plans
CESP	Certified Employment Support Professional
CFR	Code of Federal Regulations
CIT	Clinical Interdisciplinary Team
CLS	Community Learning Services
CM	Case Manager

CMB	Case Management Branch
CMO	Crisis Mobile Outreach
CMS	Centers for Medicare & Medicaid Services
CPA	Certified Public Accountant
CPI	Crisis Prevention Institute
CPR	Cardiopulmonary Resuscitation
CRB	Community Resources Branch
CTH	Crisis Telephone Hotline
CWS	Child Welfare Services
DCP	Discovery & Career Planning
DD	Developmental Disabilities
DD AFH	Developmental Disabilities Adult Foster Home
DD Dom	Developmental Disabilities Domiciliary Home
DDD	Developmental Disabilities Division within the Hawaii DOH
DHS	Hawaii Department of Human Services
DHS-MQD	Department of Human Services – Med-QUEST Division
DMO	DHS Medicaid Online
DO	Doctor of Osteopathy
DOH	Hawaii Department of Health
DOH-DDD	Department of Health – Developmental Disabilities Division
DOH-DDD-CRB	Department of Health – Developmental Disabilities Division – Community Resources Branch
DOH-OHCA	Department of Health – Office of Health Care Assurance
DSW	Direct Support Worker

DSW-CD	Direct Support Worker – Consumer Directed
E-ARCH	Extended Adult Residential Care Home
e-Crim	Hawaii’s Adult Criminal Information
EAA	Environmental Accessibility Adaptation
EFT	Electronic Fund Transfer
EPSDT	Early Periodic Screening Diagnosis and Treatment
FBA	Functional Behavioral Assessment
FDA	Food Drug Administration
GT	Gastrostomy
HAR	Hawaii Administrative Rules
HCBS	Home and Community Based Services
HIePRO	State of Hawaii Procurement
HIPAA	Health Insurance Portability & Accountability Act
HRS	Hawaii Revised Statutes
IADL	Instrumental Activities of Daily Living
ICAP	Inventory for Client and Agency Planning
ICE	In Case of Emergency
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ID	Intellectual Disabilities
I/DD	Intellectual and Developmental Disabilities
IEP	Individualized Educational Plan
IES	Individual Employment Supports
IP	Individual Plan

ISP	Individualized Service Plan
IV	Intravenous
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LOC	Level of Care
LP	Licensed Psychologist
LPN	Licensed Practical Nurse
LTC	Long Term Care
MAR	Medication Administration Record
MD	Medical Doctor
MQD	Med-QUEST Division within the Hawaii DHS
NG	Nasogastric
NOA	Notice of Action
OHCA	Office of Health Care Assurance
OHS	Out-of-Home Stabilization
OT	Occupational Therapy
OTC	Over-the-Counter
PA	Physician Assistant
PAB	Personal Assistance/Habilitation
P&P	Policies & Procedures
PBS	Positive Behavioral Supports
PERS	Personal Emergency Response System
PICC	Peripherally Inserted Central Catheter

PRN	Pro Re Nata (circumstances or as the circumstance arises)
PT	Physical Therapy
PUC	Public Utilities Commission
QA	Quality Assurance
QA/I	Quality Assurance/Improvement
QI	QUEST Integration
QAIP	Quality Assurance and Improvement Program
RBT	Registered Behavior Technician
ResHab	Residential Habilitation
RN	Registered Nurse
SIS	Supports Intensity Scale
SMES	Specialized Medical Equipment & Supplies
SSPV	Service Supervisor
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SSP	State Supplemental Payment
STF	Special Treatment Facility
TB	Tuberculosis
T&C	Training & Consultation
TLP	Therapeutic Living Program
TPN	Total Parenteral Nutrition
TST	Tuberculin Skin Test
U.S.C.	United States Code

APPENDIX 3

ASSISTANCE DIRECTORY

ASSISTANCE DIRECTORY

AGENCY	ADDRESS	PHONE
Application Provider Address Changes	DOH-DDD-Community Resource Branch Diamond Head Health Center 3627 Kilauea Ave., Rm. 411 Honolulu, HI 96816	(808) 733-2135
Conduent – Hawaii Fiscal Agent	P.O. Box 1220 Honolulu, HI 96807	(808) 952-5570 Oahu 1-800-235-4378 Neighbor Islands
DHS-MQD Member and Provider Relations Section	P.O. Box 700190 Kapolei, HI 96709-0190	(808) 692-8099 (808) 692-8094
DOH-DDD Case Management Branch (CMB)	DOH-DDD CMISB Diamond Head Health Center 3627 Kilauea Avenue, Rm. 104 Honolulu, HI 96816	(808) 733-9172
DOH-DDD Community Resource Branch (CRB)	DOH-DDD-CRB Diamond Head Health Center 3627 Kilauea Avenue, Rm. 411 Honolulu, HI 96816	(808) 733-2135
DOH-DDD Division	DOH-DDD Division Office 1250 Punchbowl Street, Rm. 463 Honolulu, HI 96813	(808) 586-5840
Medicaid Eligibility Verification	DHS Automated Voice Response Systems (AVRS) Available 24/7 Requires 10 step registration process (SEE AVRS Quick Reference Sheet)	1-800-882-4608
Medicaid Investigation Division Dept. of Attorney General	Medicaid Fraud Control Unit Office of the Attorney General c/o Dawn Shigezawa 333 Queen Street, 10 th floor Honolulu, HI 96813	(808) 586-1058 (808) 586-1077 (fax)
Medicaid Fraud Reporting	<u>Medicaid Fraud Control Unit</u>	
Med-QUEST Customer Service / Enrollment Center	<u>Med-Quest Enrollment Application</u>	1-800-316-8005 1-877-628-5076

QUEST Integration Health Plan

HEALTH CARE PLAN	PHONE	E-MAIL
AlohaCare	1-877-973-0712	Alohacare.org
HMSA	1-800-440-0640	Hmsa.com
Kaiser Permanente	1-800-651-2237	Kpinhawaii.org
Ohana Health Plan	1-888-846-4262	Ohanahealthplan.com
United Healthcare Community Plan	1-888-980-8728	Uhcommunityplan.com/hi

APPENDIX 4

PARTICIPANT SAFEGUARDS

APPENDIX 4A: P&P #2.01 POSITIVE BEHAVIOR SUPPORTS



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Positive Behavior Supports

Policy #: 2.01

PURPOSE:

Historically interventions used for people with intellectual and developmental disabilities (I/DD) have been unacceptably intrusive, focused primarily on punitive consequences, inappropriate for integrated settings, and/or ineffective in producing meaningful changes. Positive Behavior Supports (PBS) are preferable because they are effective in improving behavior and quality of life for people with behavioral challenges. The Developmental Disabilities Division (DDD) is committed to using approaches that will increase the safety, independence and overall well-being of participants receiving services. While the goal of this policy is to safely support participants who may engage in challenging behaviors, it also strives to promote participants' engagement in integrated activities.

The fundamental features of this policy include a foundation built on person-centered values, a commitment to outcomes that are meaningful, and services individualized to each participants' unique interests and strengths. The primary purposes of this policy are to commit to approaches that embrace the unique strengths and challenges of each participant, and engage each participant's circle of support as partners in developing and implementing PBS using least restrictive interventions. When a participant presents behaviors that put them at imminent risk of hurting themselves or others, PBS shall be used, whenever possible, to decrease the behaviors that pose a risk. When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary (*refer to Policy 2.02, Restrictive Interventions*). Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others. Ultimately, this policy sets forth the core values of supporting participants to the best of their abilities by expanding opportunities and enhancing quality of life using PBS approaches.

DEFINITIONS:

"Behavior Support Plan" or "BSP" is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person's team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;

3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Person-Centered Planning” means an ongoing process directed by the participant that helps individuals in his or her circle learn how the participant wants to live and describes what supports are needed to help the participant move toward a life considered meaningful and productive.

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Trauma Informed Care” or “TIC” is a developmentally appropriate, strengths-based approach that creates opportunities for people who have experienced trauma to rebuild a sense of control and empowerment. TIC is grounded in an understanding of and responsiveness to the impact of trauma and emphasizes physical, psychological, and emotional safety for both providers and survivors. It involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to maintain and/or exacerbate the impact(s) of trauma and/or re-traumatize individuals who have histories of trauma. It upholds the importance of consumer participation and choice in the development, delivery, and evaluation of services. When appropriate for a participant, TIC recognizes trauma recovery as a primary goal of treatment which involves systems integration and a basic understanding of trauma, triggers, and the impact trauma may have had on a participant’s development and coping.

CORE PRINCIPLES:

PBS methods should be the primary interventions used to maintain the safety of participants and others, promote the independence of participants, and safely support participants who engage in challenging behavior(s). The following principles serve as the foundation for guiding and implementing PBS interventions with participants:

- A. **Respect:** All participants must be treated with respect and dignity. All interventions must be free from practices or interactions that are degrading, humiliating, painful, or harmful.

- B. **Least Restricted Intervention:** Ensure that the most proactive, effective, and least intrusive methods are utilized.
- C. **Person-Centered Services:** Specific needs of each participant are identified based on an individualized assessment that incorporates the preferences, values, lifestyles, strengths and abilities, and social circumstances of the participant.
- D. **Most Integrated Setting:** A setting that enables participants with disabilities to interact with non-disabled persons to the fullest extent possible.
- E. **Meaningful Activities:** Participation in meaningful and purposeful activities that are interesting and motivating as determined by the participant.
- F. **Independence:** Participants learn functional skills, which are used in their daily routine and necessary to participate in the community in order to enhance their quality of life.
- G. **Individualization:** Behavioral interventions are designed to meet the unique and individual needs of the participant.
- H. **Choice:** Encourage individual choice in daily decision-making.
- I. **Access to Services:** Participants should have timely access to quality services.
- J. **Family Support:** It is essential for the circle of support members, particularly family and caregivers, to participate as partners in the design of behavioral interventions. Families and/or caregivers may often need continuous support when developing and/or implementing behavioral interventions.
- K. **Cultural Competency:** Support of a participant should incorporate the priorities and needs of the individual as well as his/her cultural and ethnic backgrounds and values.
- L. **Collaboration:** Effective change is achieved through the circle of support working together to understand the goals and recommended strategies. Collaboration ensures that members of the circle have adequate resources and support to consistently implement the recommendations.
- M. **Consistency:** Ensure consistency and continuity between and within services. The behavioral supports must be compatible and sustainable with existing routines in the participant's natural environment.
- N. **Communication:** Involve all members of the participant's circle of support, including but not limited to family members, caregivers, friends, service supervisors and direct support staff. Ensure clear communication of the interventions to those directly involved.
- O. **Skill Development:** An absolute belief that every participant has the potential to learn new adaptive skills, with all members of the participant's circle of support working to determine how to teach such skills to meet the unique strengths and capabilities of the participant.
- P. **Trauma Informed Care:** An organizational structure and framework that involves comprehensive understanding, recognizing, and responding to the effects of all forms of trauma, when warranted by the individualized needs of the participant.

POLICY:

DDD establishes that PBS practices and procedures - which serve to support a participant's engagement in positive behaviors and helps them to lead meaningful and productive lives - shall be the primary interventions used when supporting participants. This Policy applies to services authorized by the participant's Case Manager (CM).

- A. A BSP will be developed to support participants who engage in behaviors that threaten the health and safety of themselves or others, or that limits or prohibits the participant from engaging in an integrated activity. PBS approaches shall be the primary interventions proposed for use in a BSP to safely address challenging behaviors and increase a participant's independence and integration into community activities.
- B. A BSP will take into account an understanding of the participant's behavior by collecting and using data to make decisions. When appropriate, a trauma-informed care approach will be incorporated into a BSP to meet the individual needs of a participant with a history of trauma and/or abuse.
- C. A BSP will be developed and implemented for all participants receiving more than a 1:1 staff ratio with services in place to address health and safety goals, with regards to reducing challenging behaviors. The BSP must include recommendations and criteria on when to transition to a 1:1 staff ratio.
- D. The BSP must be overseen by a qualified DDD provider.

PROCEDURES:

- A. A BSP must be developed by a licensed professional in accordance with Hawaii state law.
- B. The Clinical Interdisciplinary Team (CIT) or designee may assist with assessing any medical, trauma, and/or mental health concerns that may impact the onset or exacerbation of challenging behaviors.
- C. The BSP is developed using the following set of criteria;
 - 1. Building a PBS team: The PBS team members are anyone who provides services or support to the participant. These members must coordinate their work at all times when developing, implementing, and/or monitoring the participant's BSP.
 - 2. Person-Centered: It is important to identify goals that are not only limited to addressing challenging behaviors, but goals that also enhance the participant's overall quality of life. The following questions shall be considered when developing goals:
 - a. How can participation and inclusion in the participant's home and community be increased?
 - b. How can we increase the meaningful activities that a participant engages in?
 - c. What would increase or strengthen the participant's social support?
 - d. How can we increase a participant's ability to make appropriate choices and control aspects of their life?
 - e. What barriers may interfere with the participant's progress?
 - 3. Defining the Target Behaviors: In order to monitor the outcomes of an intervention, specific behaviors of interest, also known as target behaviors, need to be defined in a concrete and observable manner. This definition should be written in clear, concise, and measurable objective terms (what the participant does or says). Target behaviors may be defined by answering the following questions:
 - a. What does the behavior look or sound like?
 - b. How often does the behavior occur (e.g., frequency, duration measure)?
 - c. How intense is the behavior (e.g., does the behavior result in bruising or breaking of skin)?

- d. Is the behavior harmful to the participant or others?
- e. Does the behavior result in property damage?
- f. Does the behavior prohibit or limit the participant's engagement in integrated activities?
- g. Is the progress of the participant or others being affected?
- 4. Functional Behavioral Assessment: The FBA must include the following components:
 - a. Review of relevant records, such as but not limited to, Adverse Event Reports, Individualized Service Plans (ISP), and/or provider quarterly reports.
 - b. Interviews with multiple people who interact with the participant regularly in different settings and activities.
 - c. Direct observations of the participant across multiple settings, activities and interactions with various people.
 - d. Individualized assessments to determine broader variables affecting the participant's behavior.
 - e. Collection and analysis of objective information regarding the following:
 - 1) Baseline data of the challenging behavior as well as signals that indicate more serious behavior is about to occur (e.g., threatening gestures, pacing, muttering).
 - 2) Antecedents (conditions that precede the occurrence of the participant's behavior) such as the time, setting, activity, and the people who are present or absent when challenging behaviors occur.
 - 3) Consequences (conditions that immediately follow the occurrence of the participant's behavior), such as if staff respond to the behavior by giving attention or removing undesirable activities.
 - 4) Setting events (ecological or motivational conditions) such as lack of sleep, skills deficits, change in routines, illness, or difficulties with crowded places.
 - f. One or more statements that summarize the patterns of behaviors, including the triggers and consequences, and offers an educated hypothesis for the function of the challenging behaviors and what may be maintaining it based on the objective data collected.
- 5. BSP Development: The FBA provides the basis for developing the BSP. The date(s) each of the FBA component activities (detailed in item 4 above) occurred must be documented in the BSP. This should include relevant details regarding the FBA activity completed (e.g., where an observation took place, the date, and who was present; who was interviewed, the date, and findings; what assessment was administered, the date, and results) as well as a list of the records that were reviewed by the author of the BSP, including the date indicated on the record and relevant information/findings.

The BSP facilitates the attainment of broad goals identified by the team and promotes the sustainability of the behavioral change. The BSP must include:

- a. Modifications to the social or physical environment that may prevent the challenging behavior and/or increase the likelihood of alternative appropriate behaviors.
 - b. Identification of specific behaviors or skills to teach and/or reinforce that will achieve the same function as the challenging behavior and that will allow the person to more effectively manage or respond to the environment.
 - c. Strategies for managing consequences so that positive reinforcement is provided for proactive behaviors.
 - d. Interventions that should be utilized during earlier stages of behavior escalation to prevent imminent risk of harm to the participant or others.
 - e. Detailed information on how data will be collected and analyzed by individuals implementing the BSP to evaluate the effectiveness of the plan for *each* objectively defined target behavior and goal.
 - f. An outline of crisis management procedures and the conditions in which they should be applied, should it be necessary to implement in order to ensure safety and rapid de-escalation of challenging behaviors.
 - g. Detailed information on how the author of the BSP will train all members in the participant's circle of support as well as documentation of how these individuals respond to the training (e.g., are they able to independently apply interventions appropriately). The service supervisor and caregiver(s) must be involved in the training of the BSP.
 - h. PBS strategies shall be the primary interventions used when supporting participants. If a restrictive intervention is proposed for use in a BSP, these interventions shall only be used on an emergency basis to prevent imminent risk of harm to the participant and/or others and applied only after less restrictive interventions were used and deemed ineffective, with appropriate documentation demonstrating their ineffectiveness. DDD's requirements regarding the documentation, data, training and supervision, interventions, and plans that must be included in BSPs involving restrictive interventions are detailed in *Policy 2.03, Behavior Support Review*.
6. Implementation and Monitoring: Specific procedures for implementing each intervention must be outlined in the BSP and progress toward the goals must be monitored as defined below:
- a. The PBS team must discuss and document the training(s), support(s), and/or other resources that may be needed to implement the BSP (e.g., supplementary aids or equipment).
 - b. The BSP must include specific objectives and activities, identify responsible persons, and set reasonable timelines.
 - c. Training on the BSP must be provided to all members of the PBS team and shall include, but not be limited to, a review of written materials, PBS approaches, and other interventions individualized for the participant, face-to-face behavioral modeling and coaching, feedback on the application of an intervention, instructions on data collection and review methods, and assistance in restructuring

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- routines, curriculum, instructional strategies, schedules and/or activities to minimize the likelihood of a challenging behavior.
- d. Plan implementation must be monitored through observation and data analysis to ensure intervention strategies are implemented appropriately and consistently across settings.
 - e. Objective data must be collected to evaluate the effectiveness of the BSP. Data should include decreases in challenging behavior, increases in replacement skills, achievement of broader goals, and staff implementation.
 - f. The PBS team must communicate regularly on a schedule defined by the team, to review progress and adjust the BSP as necessary.
 - g. The goals of the BSP shall be incorporated into the participant's Individualized Service Plan (ISP) by the participant's CM.
- D. An initial authorization of Training & Consultation (T&C) for Behavior Analysis may be authorized by the CMB Section Supervisor for a limited number of hours (up to five hours). The purpose of the initial T&C authorization is to enable a qualified provider to make a determination based on data of the need for a formal request to the CIT for additional hours of T&C to complete the FBA and BSP.
- E. The CIT shall make the decision whether or not to authorize T&C hours for a licensed professional in accordance with Hawaii state law to complete a FBA and BSP.
- F. The CMB Section Supervisor may authorize the author of the BSP to provide ongoing monitoring of the implementation of the BSP, retraining on the BSP, if necessary, and the collection and review of relevant data. This ongoing monitoring shall not exceed four (4) hours per month at a maximum of 6 months following completion of the initial training on the BSP. These hours shall not be used by the author of the BSP to complete tasks or other duties that are the responsibility of the DDD provider's service supervisor. A request for additional hours per month and/or an extension of the ongoing monthly supervision by the author of the BSP must be requested through the CIT. The CIT may authorize additional hours following a review of data and/or documentation which demonstrates the need for increased hours and provides detailed information regarding how previously authorized T&C hours were utilized. The author of the BSP or his/her designee shall also provide the CIT with a detailed description of how the additional hours will be used each month to improve the implementation of the BSP and/or collection of data.
- G. The CM must initiate contact with a T&C provider within five (5) working days of receiving written authorization from the CIT. The CM must report back to the Case Management Branch (CMB) Section Supervisor if a T&C provider has not been retained within 14 calendar days from the date the T&C approval was received. The Unit Supervisor may call the Section Supervisor of the Community Resource Management Section (CRMS) within the Community Resources Branch (CRB) for assistance in locating a provider.
- H. Once the FBA is completed, a BSP must be developed and written within 14 calendar days and shall include the date (month, day, and year) the BSP report was completed as well as the name of the author and his/her credentials. A final copy of the BSP report shall be forwarded by the author to the CM within 2 business days of the date of
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completion indicated on the BSP report. Refer to *Policy 2.02, Restrictive Interventions*, for additional BSP requirements.

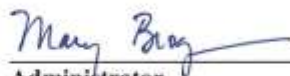
- I. Training must be initiated by the author of the BSP within 7 calendar days of the completion date indicated on the BSP and shall include a face-to-face training of, at minimum, all of the interventions and data collection methods included in the BSP by the author for all individuals in the participant's circle of support.
- J. Documentation of challenging behavior(s), including the effectiveness of the recommendations and/or interventions indicated in the BSP, shall be reported by the DDD provider to the CM every quarter or more frequently, as documented in the ISP.
- K. If a restrictive intervention is included in a BSP to address a challenging behavior, such interventions are permitted only when PBS strategies and less restrictive interventions have been applied first and deemed ineffective. Refer to *Policy 2.03, Behavior Support Review*, for the DDD's requirement specifications for BSPs that include restrictive interventions as well as when review by the Behavior Support Review Committee is required.
- L. The BSP must be reviewed at least annually by the participant's circle of support and updated as needed.
- M. A copy of the participant's current BSP must be accessible at the participant's home, and to all staff who work with the participant at the setting in which the DDD service is provided.
- N. Staff who work with the participant must implement the procedures as written in the BSP. If modifications are needed, staff must refer to a qualified professional.
- O. At minimum, the author of the BSP must remain on the participant's team until training and implementation of the plan is completed. The author should also be available to provide periodic monitoring of the BSP (not to exceed four hours per month) to ensure that it is being consistently and correctly implemented by all individuals in the participant's circle of support. If the author of the BSP is unable to provide ongoing monitoring of the BSP, he or she must appoint an appropriate designee who complies with Hawaii state law before transitioning off the team. It is at the discretion of the PBS team, with support from the CIT, to request another licensed professional in accordance with Hawaii state law to assume responsibility of the BSP.
- P. The DDD provider's service supervisor needs to demonstrate a level of competency on the BSP following training from the licensed professional in accordance with Hawaii state law who developed the plan.
- Q. All staff who implement the BSP must comply with Hawaii state law. A licensed professional in accordance with Hawaii state law shall train on the implementation of the BSP and provide periodic monitoring of BSP implementation.
- R. T&C services will not duplicate services provided through another source, including Applied Behavior Analysis (ABA) services covered by a participant's commercial insurance or, if the participant is under 21 years of age, through the Early Periodic Screening Diagnostic and Treatment (EPSDT) services under the Medicaid QUEST Integration Health Plan. When a participant has a BSP developed through another source (e.g., Department of Education, QUEST Integration, and private insurance), T&C may be authorized to develop a BSP to address behaviors that occur in settings where DDD

services are provided. The author of the BSP shall ensure consistency amongst and across the services the participant receives by consulting with the authors of the other BSPs and their treatment teams and utilizing similar interventions in settings where DDD services are provided, where appropriate. This T&C shall include training in implementing the BSP strategies and approaches during waiver service hours, as well as providing periodic monitoring of the BSP to ensure consistency.

AUTHORITATIVE & OTHER REFERENCES:

1. Koegel, L.K., Koegel, R.L., & Dunlap, G (1996). *Positive behavior support: Including people with difficult behavior in the community*. Baltimore: Paul H. Brookes Publishers.
2. O'Neill, R.E., Horner, R.H., Albin, R. W., Sprague, J.R., Storey, K., & Newton, J.S. (1997). *Functional assessment and program development for problem behavior: A practical handbook*. Pacific Grove, CA: Brooks/Cole.
3. Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014
4. Chapter 465D, HRS, "Behavior Analysts"¹
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm
5. DD Policy 2.02, Restrictive Interventions
6. DD Policy 2.03, Behavior Support Review

Approved:



Administrator
Developmental Disabilities Division

Date: FEB 17 2017

¹This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4B: P&P #2.02 RESTRICTIVE PROCEDURES



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Restrictive Interventions

Policy #2.02

BACKGROUND:

When a participant presents behaviors that places him/her at imminent risk of hurting themselves or others where steps must be taken to prevent harm, positive behavior supports (PBS) shall be used, whenever possible, to decrease the behaviors that pose risk to the person or others, and prevent the need for restrictive interventions (*refer to Policy 2.01, Positive Behavioral Supports*). When PBS techniques have been used and are not effective in resolving the immediate risk of harm, restrictive interventions that involve temporary restrictions may be necessary. Behavioral support plans (BSP) containing restrictive interventions are the least desirable approach to supporting participants and should only be utilized for the protection of the participant and others.

PURPOSE:

The purpose of this policy is to ensure that participants are supported in a caring and responsive manner that promotes dignity, respect, trust and free from abuse. Participants have all the same rights and personal freedoms granted to people without disabilities. This shall be accomplished by ensuring that:

- PBS methods are the primary interventions used to maintain the safety of participants and others, promote the independence of participants, and safely support participants who engage in challenging behavior;
- Services, supports, and/or BSPs are based on a thorough understanding of the participant and the reason why they are engaging in a challenging behavior (i.e., the function of the behavior);
- A pattern of behavior escalation has been identified and the BSP includes corresponding, least restrictive interventions to prevent or minimize the escalation of the challenging behavior at each phase to prevent imminent risk of harm;
- Restrictive measures are used only after PBS and/or less restrictive interventions were tried and documentation demonstrates that these interventions were ineffective at reducing the risk of imminent harm to the participant or others;
- Opportunities are provided for participants to exercise choice in matters affecting their everyday lives and are supported in choices that yield positive outcomes; and

- The Developmental Disabilities Division (DDD) system in Hawaii moves to a trauma-informed system, free from the use of restraints and restrictive interventions.

DEFINITIONS:

“Aversive Procedures” means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include, but are not limited to, electric skin shock, liquid spray to one’s face, and strong, non-preferred tastes applied in the mouth.

Aversive Procedures are prohibited and shall not be used with participants.

“Behavior Support Plan” or “BSP” is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person’s team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;
3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Overcorrection” is a behavioral intervention used to decrease an undesired behavior by having the individual either restore the environment to an improved state vastly better than it was prior to the undesired behavior (e.g., cleaning or fixing the environment) and/or repeatedly performing the appropriate way to do a behavior as a result of engaging in the undesirable behavior (e.g., repeatedly closing the door in an appropriate manner as opposed to slamming it closed or repeatedly requesting someone’s attention by saying their name in an appropriate manner as opposed to throwing an item at them). **Overcorrection is prohibited and shall not be utilized with participants.**

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Provider” means any individual or agency delivering a service authorized through DDD inclusive of consumer directed services.

“Restraint” means a physical, chemical or mechanical intervention used as a last resort on an emergency basis to protect the participants from imminent harm to themselves and/or others using the least restrictive intervention possible and for the shortest duration necessary.

THE FOLLOWING ARE NOT CONSIDERED RESTRAINTS:

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
 - A device used to protect the participant’s safety as indicated in the Individualized Service Plan (ISP) per a physician’s recommendation and reviewed by the Behavior Support Review Committee (BSRC); or
 - Vehicular passenger restraint systems required by state law (HRS §291-11.6).
1. **“Chemical Restraint”** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
- a. On a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or
 - b. Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the individual.

THE FOLLOWING ARE NOT CONSIDERED CHEMICAL RESTRAINTS:

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the American Psychiatric Association’s Diagnostic and Statistical Manual (DSM);
 - Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
 - Medications prescribed to control seizures; and
 - Medications for medical or dental procedures.
2. **“Mechanical Restraint”** means an intervention involving a device, material or equipment that is involuntarily applied to the participant’s body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement in emergency situations to prevent the participant from harming themselves or others. See definition of “Restraints” for interventions that are not considered a Mechanical Restraint.
3. **“Physical Restraint”** means an intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to a

portion or portions of their body. See definition of "Restraints" for interventions that are not considered a Physical Restraint.

"Restrictive Intervention" or "Restrictive Procedure" means a practice that limits a participant's freedom of movement, access to other locations, property, individuals, or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

"Seclusion" means a restrictive intervention in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. **Seclusion is prohibited and shall not be utilized with participants.**

POLICY:

This policy dictates that restrictive interventions are only to be used when a participant's behavior(s) pose an imminent risk of harm to themselves and/or others and less restrictive interventions have been attempted with limited effectiveness at reducing and/or replacing the challenging behavior. The restrictive interventions utilized must be the least restrictive method to address the challenging behavior and shall be terminated when there is no longer an imminent risk of harm and/or a less restrictive intervention would achieve the same purpose. This policy also describes which restrictive interventions are allowed and which are prohibited when providing services to participants, the circumstances under which allowed restrictive interventions may be used, and the requirements that must be met. The fundamental features of this policy specifies that restrictive interventions are:

- Only meant to address situations of imminent risk of harm.
- Not to be used as threats or punishment to change behavior as participants have the right to be free from any restrictive intervention imposed for the purpose of discipline, retaliation and/or staff convenience.
- Not therapeutic in nature nor designed to alter behavior in a long-term manner so should not be utilized with this intent.

When behavioral data and the Individualized Service Plan (ISP) team confirms an imminent risk of harm to the participant and/or others, and it is documented that less restrictive interventions have been attempted and deemed ineffective at decreasing the risk of harm, a BSP with restrictive intervention(s) may be developed that contains the following features:

- PBS methods as the primary interventions to safely address challenging behaviors and increase a participant's independence and integration into community activities.
- Restrictive interventions that are only used to protect the participant and/or others from imminent risk of harm after less restrictive interventions have been applied and deemed ineffective at addressing the challenging behavior, with appropriate documentation demonstrating their ineffectiveness.
- The specific conditions that warrant the use and removal of the restrictive intervention as well as procedures to restore the restricted right(s) of the participant following the use of a restrictive intervention.

- Strategies to prevent or minimize the challenging behaviors from occurring as well as identification of replacement skills that will be taught to the participant that serve the same function as the challenging behavior. Goals should also be identified in the BSP that enhance the participant's overall quality of life so that treatment objectives are not limited to addressing challenging behaviors only.
- Specific instructions on how documentation and/or data collection should be completed following the use of a restrictive intervention. The staff involved in the application of the restrictive intervention shall debrief the incident with the service supervisor overseeing the BSP within 24 hours of the initial application of the restrictive intervention (*refer to page 8 of this policy for specific provider requirements following the use of a restrictive intervention*). Adjustments to the BSP may be made by the author of the BSP or his/her designee if needed.
- A detailed plan for the eventual elimination of the restrictive intervention.

The procedures that are prohibited and shall not be used with participants include but are not limited to:

- Seclusions
- Aversive procedures involving:
 - Electric shock (excluding electroconvulsive therapy);
 - The non-accidental infliction of physical or bodily injury, pain, or impairment, including but not limited to hitting, slapping, causing burns or bruises, poisoning, or improper physical restraint;
 - Unpleasant tasting food or stimuli; and
 - Contingent application of any noxious substances which include but are not limited to noise, bad smells, or squirting a participant with any substance that is administered for the purpose of reducing the frequency or intensity of a behavior.
- The following types of restraints:
 - Restraints that cause pain or harm to participants. This includes restraint procedures such as arm twisting, finger bending, joint extensions or head locks;
 - Prone Restraints;
 - Supine Restraints;
 - Restraints that have the potential to inhibit or restrict a participant's ability to breathe; excessive pressure on the chest, lungs, sternum, and/or diaphragm of the participant; or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;
 - Restraint Chairs;
 - Restraint Boards;
 - Any maneuver that involves punching, hitting, poking, or shoving the participant;
 - Straddling or sitting on the torso;
 - Any technique that restrains a participant vertically, face first against a wall or post; and
 - Any maneuver where the head is used as a lever to control movement of other body parts.

- Interventions involving:
 - Verbal or demonstrative harm caused by oral, written language, or gestures with disparaging or derogatory implications;
 - Psychological, mental, or emotional harm caused by unreasonable confinement, intimidation, humiliation, harassment, threats of punishment, or deprivation;
 - Denial of food, beverage, shelter, bedding, sleep, physical comfort or access to a restroom as a consequence of behavior;
 - The restriction or disablement of a communication device;
 - Placing a participant in a room with no light;
 - Overcorrection; and
 - Removing, withholding or taking away money, incentives or activities previously earned.

PROCEDURES:

- A. A BSP must define the target behaviors being addressed by the plan and be developed by a licensed professional in accordance with Hawaii state law following the completion of a Functional Behavioral Assessment (FBA). For specific details regarding the developmental criteria of a BSP, refer to *Policy 2.01, Positive Behavioral Supports*.
- B. All staff who implement the BSP must comply with Hawaii state law. A licensed professional in accordance with Hawaii state law shall train on the implementation of the BSP and provide periodic monitoring of BSP implementation (*refer to Policy 2.01, Positive Behavioral Supports*). All provider staff who supervise the implementation of a BSP must demonstrate a level of competency on the BSP following training from the licensed professional who developed the plan in accordance with Hawaii state law.
- C. If a restrictive intervention is included in a BSP to address a challenging behavior, such interventions are permitted only when PBS strategies and less restrictive interventions have been applied and documentation demonstrates that these interventions were ineffective. Refer to *Policy 2.03, Behavior Support Review*, for the DDD's requirement specifications for BSPs that include restrictive interventions as well as when review by the Behavior Support Review Committee is required.
- D. The author of the BSP shall include a proposed training plan that should include: (1) when training of each individual in the participant's circle will occur (i.e., the projected date and timeframe), (2) what topics individuals will be trained on during a training session, (3) the individual's response to the training as well as any recommendations for follow-up trainings, and (4) how documentation of the training(s) will occur in the aforementioned areas. Documentation of the trainings received by the individual's circle, including how they responded to the training and any follow-up training recommendations, shall be maintained by the author of the BSP and available for review by the DDD. The initial review of and training on the BSP with all individuals in the participant's circle of support must be initiated by the author of the BSP within 7 calendar days of the completion date indicated on the BSP. If a review by the BSRC is required, a referral shall be made by the Case Manager to the

BSRC within 30 calendar days of the date of completion indicated on the BSP report (*refer to Policy 2.03, Behavior Support Review*).

- E. A BSP will be developed and implemented for all participants receiving more than a 1:1 staff ratio with services in place to address health and safety goals, with regards to reducing challenging behaviors. The BSP must include recommendations and specific measurable and objective criteria that indicates when a transition to a 1:1 staff ratio should commence and identify goals that are not only limited to address challenging behaviors but also goals that enhance the participant's overall quality of life.

When a restrictive intervention is proposed for use in a BSP by a licensed professional in accordance with Hawaii state law to address a challenging behavior, the BSP shall be written in accordance with the *Medicaid Waiver Standards Manual* which details the specific requirements for *each* restrictive intervention proposed for use.

F. Providers shall have:

1. Internal policies and procedures concerning restrictive interventions that are in accordance with state policies, and promote the use of positive behavior support approaches with the goal of eliminating the use of restrictive interventions;
2. A plan for recording and maintaining data on the use of restrictive interventions;
3. A plan for monitoring the outcomes of a restrictive intervention, its efficacy, and the continued need for its use in the BSP;
4. All staff who implement the BSP comply with Hawaii state law;
5. A licensed professional in accordance with Hawaii state law develop the BSP, train on the implementation of the BSP, and provide periodic monitoring of the implementation of the BSP (*refer to Policy 2.01, Positive Behavior Support*);
6. The staff administering the restrictive intervention be trained on the participant's BSP by the licensed professional who developed the plan. The initial training of all interventions proposed for use in the BSP shall occur in person with the author of the BSP and the individuals who will be implementing the BSP. Training should be received both prior to providing services to the participant and on an ongoing basis throughout the duration of services provided to the participant. Only specific restrictive interventions proposed for use in the BSP to address a specific behavior can be utilized. Documentation of the training received by the staff administering the restrictive intervention, including their response to the training(s) and recommendations for follow-up trainings, shall be maintained by the author of the BSP. Documentation of the supervision received by staff should be maintained in the provider agency's files. Both shall be available for review by the DDD;
7. Staff who provide services to participants whose treatment plans include restrictive intervention(s) trained in a nationally-recognized curricula approved by DDD. A component of these curricula includes de-escalation and re-direction techniques to be used prior to a restraint as well as crisis management and intervention techniques. In addition, staff must be trained on the participant's individualized BSP which focuses on utilizing non-aversive methods as a primary intervention;

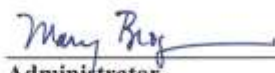
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8. A copy of the BSP at the site where services for the participants are provided; and
 9. Written consent for the BSP from the participant, guardian and/or care team.
- G. During the use of a restrictive intervention, providers shall ensure that:
1. The participant is monitored for health and safety throughout the duration of the restrictive intervention with staff being continuously present and observing the participant's condition. This includes, but is not limited to, monitoring the participant's breathing, consciousness and pain;
 2. Mechanical and/or Physical Restraints are terminated immediately after the imminent risk of harm to self or others is no longer present;
 3. The start time and end time of the application and removal of a Mechanical and/or Physical Restraint are documented;
 4. Participants who are administered a chemical restraint must also be monitored for side effects or adverse effects of medication until effects of medications have ended; and
 5. For Chemical Restraints used to address imminent risk of harm as outlined in a BSP, the time the medication was administered must be documented and staff must monitor the health and safety of the participant. Chemical Restraints shall not be used as a preventative intervention and shall be used in accordance with the prescribing physician's orders.
- H. After a restrictive intervention is implemented, providers shall complete:
1. Documentation of:
 - a. The type of restrictive intervention used;
 - b. The location of the intervention;
 - c. The people involved in the intervention;
 - d. The time that the restrictive intervention was initiated and terminated; and
 - e. The events proceeding and following the restrictive intervention. This shall include but not be limited to:
 - 1) Antecedent(s) to the challenging behavior, including environmental and other contributing factors;
 - 2) Less restrictive interventions that were attempted and deemed ineffective at reducing the risk of harm, including the results of those interventions;
 - 3) Consequences of the restrictive intervention; and
 - 4) How the restricted rights of participant were restored.
 2. An Adverse Event Report (AER) and submit to DDD. Any use of restraints are considered an adverse event and submission of an AER is required in accordance with *Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services*. Seclusion is prohibited by the DDD. If Seclusion is utilized to address a challenging behavior, it is considered an adverse event and submission of an AER is required.
- I. Debriefing with all staff involved in the application of the restrictive intervention shall occur with the Service Supervisor overseeing the BSP within 24 hours of the initial application of the restrictive intervention. This purpose of this debriefing is to:

1. Provide specific instructions on how documentation and/or data collection will be completed following the use of a restrictive intervention;
 2. Assess what was effective and ineffective with regards to the interventions used throughout the escalation of the behavior;
 3. Determine what could have been done before, during, and/or after the restrictive intervention to minimize the likelihood of the challenging behavior and/or prevent the risk of harm;
 4. Assess how the safety and well-being of the participant was monitored throughout the application of the restrictive intervention;
 5. Determine antecedent-based interventions that should be utilized in the future to minimize the likelihood of the challenging behavior from occurring; and
- Adjustments to the BSP may be made by the author of the BSP or his/her designee, if needed, based on the findings of this debriefing.

AUTHORITATIVE & OTHER REFERENCES:

1. Chapter 465D, HRS "Behavior Analysts":
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm.¹
2. Cooper, J.O., Heron, T.E., & Heward, W.L. (2007). *Applied Behavior Analysis, 2nd Edition*. Saddle River, NJ: Pearson Publishing.
3. DD Policy 2.01, Positive Behavioral Supports
4. DD Policy 2.03, Behavior Support Review
5. DD Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services

Approved: _____

Administrator
Developmental Disabilities Division

Date: FEB 17 2017

¹ This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4C: P&P #2.03 BEHAVIOR SUPPORT REVIEW COMMITTEE



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Behavior Support Review

Policy #: 2.03

BACKGROUND:

The purpose of therapeutic interventions when working with individuals with Intellectual and Developmental Disabilities (I/DD) is to provide individuals with support strategies and therapeutic approaches that are tailored to their specific needs. This allows individuals to strengthen their ability to live productive and satisfying lives in the community and ensures that the rights of individuals with I/DD are not violated. When participants of the Developmental Disabilities Division (DDD) present behaviors that put them at imminent risk of hurting themselves or others, steps must be taken to prevent harm. Positive behavior supports (PBS) (*refer to Policy 2.01, Positive Behavioral Supports*) shall be used, whenever possible, to decrease behaviors that pose a risk of harm to self or others, and prevent the need for restrictive practices.

The DDD policy on PBS ensures that behavioral interventions are implemented by trained and supervised staff and documented appropriately to assist and support participants receiving services, and those providing support to them. When PBS techniques have been attempted and are not effective at reducing risks of harm, restrictive interventions that involve safe and temporary restrictions may be necessary (*refer to Policy 2.02, Restrictive Interventions*). Restrictive interventions should only be used in the context of a comprehensive, functional approach to behavior support that is designed to teach, nurture, and encourage positive behaviors. Safeguards for restrictive interventions are required to ensure that a participant's rights are protected, and that interventions do not violate these rights. To minimize the use of interventions that are intrusive, focused exclusively on punitive consequences, and/or are ineffective in producing meaningful outcomes, Behavioral Support Plans (BSPs) containing restrictive interventions are the least desirable approach to supporting participants and such interventions shall be reviewed by the Behavior Support Review Committee (BSRC) to ensure the safety of participants and others.

PURPOSE:

The purpose of Behavior Support Review is to ensure that PBS methods are used when working with participants and that appropriate safeguards are in place when restrictive interventions are proposed for use in a Behavior Support Plan (BSP). The BSRC may review BSPs for which there is a restrictive intervention that meets specific DDD thresholds to address a challenging

behavior (see *Procedures* section, item A) and may provide recommendations to ensure appropriate, effective, and safe application of an intervention by service providers.

DEFINITIONS:

“Aversive Procedures” means procedures intended to inflict pain, discomfort and/or social humiliation in order to modify behavior. These include, but are not limited to, electric skin shock, liquid spray to one’s face, and strong, non-preferred tastes applied in the mouth.

Aversive Procedures are prohibited and shall not be used with participants.

“Behavior Support Plan” or “BSP” is a written plan for the team members who are supporting the person who is engaging in behaviors perceived as challenging. The BSP outlines:

1. Steps that will be taken by the members of the person’s team to modify the physical environment;
2. What replacement skills should be taught to the participant as well as how to do so;
3. Ways in which team members should respond to challenging behaviors; and
4. Ways in which team members can decrease the likelihood of challenging behaviors.

The BSP is developed based on the results of a Functional Behavior Assessment (see definition below). As BSPs include Positive Behavior Support approaches (see definition below), a BSP may also be referred to as Positive Behavior Support Plan or PBS Plan.

“Functional Behavior Assessment” or “FBA” means the process of determining the functions, or reasons why a person is engaging in challenging behaviors, and to understand the conditions in which challenging behaviors occur. The FBA involves collecting data to identify patterns or trends and to develop a hypothesis of conditions that trigger and/or maintain these behaviors prior to developing a behavior support plan.

“Licensed Behavior Analyst” or “LBA” is an individual licensed under HRS Chapter 465D.

“Positive Behavior Supports” or “PBS” is a process for addressing challenging behaviors by understanding the relationships between a person’s behavior, communication, and aspects of his or her environment. It offers strategies to modify the environment and interactions in order to prevent the occurrence of these behaviors; teaches skills to replace challenging behaviors; outlines responses to challenging behaviors to reduce the likelihood that these behaviors will reoccur in the future; and offers proactive and functional strategies to promote a positive lifestyle change. Positive Behavior Supports strategies are included in Behavior Support Plans (BSPs).

“Provider” means any individual or agency delivering a service authorized through DDD inclusive of consumer directed services.

“Restraint” means a physical, chemical or mechanical intervention used as a last resort on an emergency basis to protect the participants from imminent harm to themselves and/or others using the least restrictive intervention possible and for the shortest duration necessary.

THE FOLLOWING ARE NOT CONSIDERED RESTRAINTS:

- Interventions used for the purpose of conducting routine physical or dental examination or diagnostic tests or completing a medical or dental treatment procedure;
 - A device used to protect the participant's safety as indicated in the Individualized Service Plan (ISP) per a physician's recommendation and reviewed by the Behavior Support Review Committee (BSRC); or
 - Vehicular passenger restraint systems required by state law (HRS §291-11.6).
1. **"Chemical Restraint"** means a psychotropic medication prescribed by a licensed health care professional with prescriptive authority:
 - a. On a routine basis without an appropriate Diagnostic and Statistical Manual (DSM) diagnosis for the purpose of behavioral control; or
 - b. Incidental use of medications, sometimes called PRN or as needed medication, to restrict the freedom of movement or temporarily sedate the individual.

THE FOLLOWING ARE NOT CONSIDERED CHEMICAL RESTRAINTS:

- Medications prescribed for the treatment of a diagnosed disorder found in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM);
 - Adjusting the dose of a prescribed medication or prescribing a new medication to achieve better symptom control for the diagnostic disorder per the current DSM;
 - Medications prescribed to control seizures; and
 - Medications for medical or dental procedures.
2. **"Mechanical Restraint"** means an intervention involving a device, material or equipment that is involuntarily applied to the participant's body or immediate environment (i.e., wheelchair, chair, bed, toilet, vehicle, etc.) that immobilizes, restricts, limits, or reduces any bodily movement in emergency situations to prevent the participant from harming themselves or others. See definition of "Restraints" for interventions that are not considered a Mechanical Restraint.
 3. **"Physical Restraint"** means an intervention in which physical force is applied to the participant and involuntarily restricts their freedom of movement or normal access to a portion or portions of their body. See definition of "Restraints" for interventions that are not considered a Physical Restraint.

"Restrictive Intervention" or "Restrictive Procedure" means a practice that limits a participant's freedom of movement, access to other locations, property, individuals, or rights. This includes, but is not limited to, Chemical, Mechanical, and Physical Restraints.

“Authorized Restricted Intervention” means a restricted intervention proposed for use in a BSP by a licensed professional in accordance with Hawaii state law following the completion of a Functional Behavior Assessment.

“Seclusion” means a restrictive intervention in which a person is involuntarily confined in a room or area from which they are prevented from having contact with others or leaving by closing a door or using another barrier. **Seclusion is prohibited and shall not be utilized with participants.**

POLICY:

This policy describes how the Behavior Support Review Committee (BSRC) will review BSPs that propose the use of restrictive interventions to address challenging behaviors that pose an imminent risk of harm to the participant or others. This policy establishes that the BSRC will:

- Review specific interventions proposed in a BSP to ensure that PBS methods which promote the growth, development, and independence of participants, individual choice in daily decision-making, and self-management are the primary interventions used;
- Review and monitor BSPs that include restrictive interventions to ensure that appropriate safeguards and oversight of restricted interventions (planned or in time of crisis) are used, with planning for the eventual elimination of the restrictive intervention(s);
- Ensure that restrictive interventions are the least restrictive method available to address a challenging behavior and are utilized in combination with positive procedures designed to teach appropriate replacement behaviors that serve the same function (as opposed to suppression or elimination of undesirable behaviors); and
- Ensure that appropriate preventative strategies are in place to prevent or minimize the challenging behaviors from occurring.

When a restrictive intervention - including Chemical, Mechanical, and/or Physical Restraint - is used as a last resort intervention to prevent imminent risk of harm to self or others, a BSP must be written for *each* challenging behavior in which a restrictive intervention is proposed for use. The BSP shall be developed by a licensed professional in accordance with Hawaii state law and be in accordance with the *Medicaid Waiver Standards Manual* which details the specific requirements for *each* restrictive intervention proposed for use in a BSP. Prior to the application of a restrictive intervention, other less intrusive interventions must be attempted with appropriate documentation demonstrating their ineffectiveness at reducing and/or replacing a challenging behavior. Baseline data of the challenging behavior shall also be documented.

The Behavior Support Review Committee (BSRC) will review BSPs and supporting documents as described in the procedures below to ensure that appropriate safeguards are in place when restrictive interventions are used. This involves a systematic review to:

- Establish that a restrictive intervention will be utilized as a last resort intervention to maintain the safety of the participant and/or others at imminent risk of harm only after less restrictive

interventions have been attempted, appropriately documented, and deemed unsuccessful at addressing the unsafe behavior;

- Ensure that a pattern of behavior escalation has been identified and the BSP includes corresponding, less restrictive interventions to prevent or minimize the escalation of the challenging behavior at each phase;
- Ensure that suggested interventions in the BSP are applied by trained and supervised providers who are overseen by a qualified DDD Service Supervisor, not a Consumer Directed Personal Assistant or family member; and
- Ensure that the rights of participants are not violated. Procedures that will restore the restricted right(s) of the participant following the use of a restrictive intervention will be reviewed by the BSRC as well as interventions that will provide the participant with functional skills allowing for the eventual elimination of the Restricted Intervention.

PROCEDURES:

A. Referrals to BSRC

1. A referral by the DDD Case Manager (CM), Outcomes and Compliance Branch (OCB) staff monitoring adverse events, or Community Resources Branch (CRB) staff monitoring providers shall be made to the BSRC in the following situations:
 - a. PRN medication(s) is used to manage unsafe or challenging behavior without an appropriate DSM diagnosis;
 - b. Any restrictive intervention is proposed for use or currently being utilized with a participant less than 18 years of age;
 - c. An injury has occurred to the participant and/or others as a result of the application of a restrictive intervention;
 - d. The use of a restrictive intervention on three (3) or more instances during a one (1) month period, including but not limited to PRN medication for challenging behavior, Mechanical, and/or Physical Restraint. This includes both authorized restrictive interventions that are proposed for use in a BSP by a licensed professional in accordance with Hawaii state law as well as interventions that are not included in a BSP. This threshold may be adjusted following the BSRC's review of appropriate documentation and data;
 - e. A participant is receiving more than a 1:1 staff ratio to manage challenging behavior(s);
 - f. Challenging behavior results in psychiatric or medical hospitalization or results in the need for medical care;
 - g. An intervention prohibited by DDD was utilized including but not limited to Seclusion or any Aversive Procedure intended to inflict pain, discomfort and/or social humiliation in order to modify behavior (*refer to Policy 2.02, Restrictive Interventions*); and/or
 - h. More than two (2) restrictive interventions are proposed for use in a BSP to address challenging behavior(s).
2. The BSRC may receive referrals from other reporting sources, including but not limited to the Clinical Interdisciplinary Team (CIT) or the LBA who developed the BSP. The

CM and/or their Unit Supervisor will be contacted by the BSRC or designee to request the necessary documents for review by the BSRC.

3. The BSRC may select a participant and review all CMB and service provider records as well as interview the participant's circle of support to provide recommendations to ensure that appropriate safeguards are in place.

B. Required Documentation for Referral to the BSRC

1. All referrals to the BSRC shall be made utilizing the BSRC Referral Form.
2. When making a referral to the BSRC, the CM shall provide the following information within five (5) working days of the scheduled BSRC review for each challenging behavior for which a restrictive intervention is being utilized or proposed for implementation:
 - a. Proposed Behavior Support Plan (BSP) or current BSP if restrictive interventions have been employed prior to the approval of this Policy. The BSP shall include strategies on how to effectively address the challenging behavior and decrease the likelihood of its occurrence as well as identify alternative, functional behaviors that can be taught to the participant that serve the same purpose (see item 4 below for detailed description);
 - b. Current Functional Behavioral Assessment (FBA). The FBA shall include baseline data of the challenging behavior and a functional analysis of the purpose of the behavior as well as what may be maintaining it based on objective data collected (refer to Policy 2.01, *Positive Behavior Support*, for the required components of a FBA);
 - c. Current Individualized Service Plan (ISP) with current list of ALL medications, including diagnoses, dosage, strength, and purpose;
 - d. As documentation is required each time a restrictive intervention is utilized (refer to Policy 3.07, *Adverse Event Report for People Receiving Developmental Disabilities Division Services*) applicable Quarterly Reports should be submitted for review as well as Adverse Event Reports (AERs) from the last 12 months, at minimum;
 - e. Information about any hospitalizations including the reason for the hospitalization and the duration of the stay from the last 12 months, at minimum;
 - f. Documentation of alternative, less restrictive interventions that were attempted as a primary intervention to address a challenging behavior, including data demonstrating their limited effectiveness at reducing and/or replacing the challenging behavior (see item 3 below);
 - g. Physician Orders for PRN medications;
 - h. Physician Orders for restrictive intervention(s) used to protect the participant or others from imminent harm; and
 - i. Other information that may be applicable to the BSRC such as the Authorization for the use or Disclosure of Protected Health Information (PHI).
3. Individuals providing behavioral intervention services to the participant will be contacted by the BSRC support staff to provide the following documentation; such documentation shall be provided to the BSRC at least five (5) working days prior to the scheduled review by the BSRC:

- a. Data or information indicating the proposed antecedents and consequences to the challenging behavior;
 - b. Data or information detailing the alternative, less restrictive behavioral interventions that were attempted as a primary intervention throughout the escalation phases of the behavior and the results of those interventions;
 - c. Data or information regarding the frequency, intensity, and duration of the challenging behavior;
 - d. Data or information regarding the replacement skills that have been identified and will be taught to the participant that serve the same function as the challenging behavior; and
 - e. Information on how the participant's health and safety was monitored during the application of the restrictive intervention as well as how the restricted rights of the participant were restored following the removal of the restrictive intervention.
4. The individual referring the case to the BSRC, the CM, the LBA who developed the BSP, the provider(s) currently providing behavioral intervention services to the participant, and the provider's Service Supervisor shall be available to the BSRC, as scheduled, to address questions, provide explanation and data, clarify the participant's situation, and/or discuss alternative behavioral strategies attempted and the success/failure of those strategies.

C. Recommendations and Decisions of the BSRC

1. The BSRC shall review all available documentation and provide recommendations to (1) ensure that the rights of participants are not violated, (2) establish that PBS methods are the primary interventions used, and (3) establish that appropriate safeguards are in place when working with participants.
2. The BSRC may provide recommendations to address the following areas:
 - a. The appropriateness of the BSP and/or proposed interventions to address challenging behavior and teach appropriate replacement skills. If multiple restrictive interventions are proposed to address a challenging behavior, the BSRC will review the appropriateness of *each* restrictive intervention and may provide recommendations;
 - b. The need for medical and/or dental exams to minimize the occurrence and/or exacerbation of a challenging behavior;
 - c. The appropriateness of the participant's current list of medications as well as the method and/or schedule of administration;
 - d. Mental Health or psychiatric issues that may be impacting the challenging behavior;
 - e. Environmental and other situational factors that may be impacting the challenging behavior; and/or
 - f. Support systems and other interpersonal factors that may be impacting the challenging behavior.
3. All requests for additional information must be supported by the majority of the BSRC. The date of the next BSRC review will be established and the required documentation

must be submitted within 5 working days of the scheduled review by the appropriate source.

4. All requests for changes to the participant's BSP, ISP, Individual Plan (IP), data collection methods, and/or other documentation, methods, or, interventions - whether involving behavioral, medical, psychiatric, or other supports - must be supported by the majority of the committee for each challenging behavior. Such recommendations may include but are not limited to:
 - a. Modifications to the BSP. Any recommendations made by the BSRC shall be made by the author of the BSP and addressed *prior to* implementation of the restrictive intervention(s). The modified BSP must be submitted to the BSRC within 7 calendar days of the CM's receipt of the revised BSP from the LBA;
 - b. Additional training and/or supports needed by the participant's circle, in addition to those required by the BSP or ISP, to assist in maximizing the participant's growth and skill development as well as maintain their safety and meet their specific needs. Recommended trainings and/or supports will address the specific training needs of individuals supporting the participant so that the use of restrictive intervention(s) can be reduced or eliminated;
 - c. Additional medical, psychiatric, psychological, behavioral, and/or dental evaluation(s) to determine if challenging behaviors are caused and/or exacerbated by physical and/or medical conditions;
 - d. Additional safeguards that may be required for the safe and effective use of a restrictive intervention;
 - e. Obtaining authorization for a formal request of Training and Consultation services from the CIT (*refer to Policy 2.01, Positive Behavior Support*); and
 - f. Visitation by members of the BSRC to observe the participant in any necessary setting(s), including but not limited to the home, community, workplace, or service provider setting.
5. Any revisions recommended by the BSRC must be supported by the majority of the BSRC. The date of the next BSRC review will be established and the required documentation must be submitted by the appropriate source within 5 working days of the scheduled review.
6. The BSP shall be reviewed annually by the BSRC as long as any criteria in Item 1 of the Procedure section, *Referrals to BSRC (p. 5)*, are met. The date of annual review shall be determined by the initial review by the BSRC.
7. If there is preceding BSRC data BSRC shall analyze this data to identify trends and patterns on a quarterly basis, and develop recommendations for programmatic and/or systemic improvement through the Safety and Well-Being Committee. This shall include, but not be limited to:
 - a. How the rights of participants were violated as a result of a restrictive intervention(s) and, how the participants' rights were restored, including practices to better maintain the rights of the participant;
 - b. Restrictive interventions that require more individualized training and supervision to maintain the safety of the participant;

- c. Any medical, dental, trauma, mental health or other conditions that require a more thorough assessment to identify confounding issues that may be maintaining and/or exacerbating these conditions; and
 - d. Conditions, diagnoses, and/or challenging behaviors that require additional, individualized training to safely support a participant and ensure that PBS methods are the primary interventions used.
8. For immediate situations where there is imminent danger to the person or others, the CIT can review the proposed restrictive intervention(s) and render a temporary recommendation until the next scheduled BSRC meeting. Between BSRC scheduled meetings, CMs may also consult with the CIT to receive temporary recommendations for behavior supports and/or if they are unclear on how to meet the requests of the BSRC.

D. Composition and Responsibilities of the BSRC

- 1. BSRC Membership:
 - a. The Chairperson of the BSRC shall be from the DDD and appointed by the DDD Administrator;
 - b. One member from the DDD who is a psychologist or behavior analyst;
 - c. One Registered Nurse (RN) from DDD;
 - d. One Case Management Unit Supervisor (or designee);
 - e. OCB Chief (or designee);
 - f. One CRB member;
 - g. A volunteer of the BSRC, who may include:
 - 1) Family member or parent of a participant receiving services from the DDD;
 - 2) DDD provider agency representative;
 - 3) Community member with no direct involvement with a DDD provider agency; or
 - 4) Consumer receiving services from the DDD.
 - h. A Vice-Chair shall be appointed by the Chair of BSRC to conduct business in the absence of the chair; and
 - i. No professional whose prospective BSP is the subject of review may review and/or provide recommendations on a proposed BSP. No member may review and/or provide recommendations if there is professional, financial, or familial conflict(s) of interest.
- 2. Before participation in the BSRC, Non-State Government Employee Volunteers must:
 - a. Complete requirements of the Department of Human Resources & Development's Intra-Departmental Directive 13.01 "Utilization of Volunteer Services;" and
 - b. Complete HIPAA training
- 3. All BSRC Members are required to protect the confidentiality of all records and information disclosed in carrying out the duties and activities of the BSRC, and must sign a confidentiality agreement and receive training in HIPAA, unless they are State employees of a HIPAA covered entity.
- 4. BSRC Meetings
 - a. The BSRC shall meet monthly. The Chair, or designee, shall be responsible for informing all members of meeting dates and times and cancellation of meetings.
 - b. DDD support staff shall maintain a record that includes:

- 1) A summary of the BSRC recommendations for each BSP reviewed;
- 2) A record of attendance; and
- 3) The date of the meeting.
5. Notification of BSRC Decision
 - a. The BSRC will consult with and send a written copy of the BSRC recommendations to the assigned CM, or person referring the case to the BSRC, including a subsequent review date.

AUTHORITATIVE & OTHER REFERENCES:

1. State of Hawaii, Department of Health, Developmental Disabilities Division, "Medicaid Waiver Provider Standards Manual."
2. §333F-8, HRS, "Rights of persons with developmental or intellectual disabilities."
3. Chapter 465D, HRS "Behavior Analysts":
http://www.capitol.hawaii.gov/hrscurrent/Vol10_Ch0436-0474/HRS0465D/HRS_0465D-.htm¹
4. Department of Human Services & Development's Intra-Departmental Directive 13.01 "Utilization of Volunteer Services";
5. DD Policy 2.01, Positive Behavioral Supports
6. DD Policy 2.02, Restrictive Interventions
7. DD Policy 3.07, Adverse Event Report for People Receiving Developmental Disabilities Division Services

NOTE:

Forms related to this P&P are posted with the P&P on SharePoint for your reference & use.

Approved: _____

Mary Beogan

Administrator
Developmental Disabilities Division

Date: FEB 17 2017

¹ This hyperlink connects to the most recent version of HRS through the Hawaii State Legislature website. Hyperlinks to HRS chapters show the first page of the chapter only, to see the rest of the contents of the chapter, click "Next" on the lower right hand side of the page on your screen.

APPENDIX 4D: NURSE DELEGATION DECISION MAKING TREE

I. Introduction

There is more nursing to do than there are nurses to do it. Many nurses are stretched to the limit in the current chaotic healthcare environment. Increasing numbers of people needing healthcare combined with increasing complexity of therapies create a tremendous demand for nursing care. More than ever, nurses need to work effectively with assistive personnel. The abilities to delegate, assign, and supervise are critical competencies for the 21st century nurse.

In 2005, both the American Nurses Association and the National Council of State Boards of Nursing adopted papers on delegation.¹ Both papers presented the same message: delegation is an essential nursing skill. This joint statement was developed to support the practicing nurse in using delegation safely and effectively.

II. Terminology

Although there is considerable variation in the language used to talk about delegation, ANA and NCSBN both defined delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to do something that that person would not normally be allowed to do. Both papers stress that the nurse retains accountability for the delegation.

Both papers define assignment as *the distribution of work that each staff member is responsible for during a given work period*. The NCSBN uses the verb “assign” to describe those situations when a nurse directs an individual to do something the individual is already authorized to do, e.g., when an RN directs another RN to assess a patient, the second RN is already authorized to assess patients in the RN scope of practice.

Both papers consider supervision² to be the provision of guidance and oversight of a delegated nursing task. ANA refers to on-site supervision and NCSBN refers to direct

¹ ANA and NCSBN have different constituencies. The constituency of ANA is state nursing associations and member RNs. The constituency of NCSBN is state boards of nursing and all licensed nursing. Although for the purpose of collaboration, this joint paper refers to registered nurse practice, NCSBN acknowledges that in many states LPN/VNs have limited authority to delegate.

² ANA defines supervision to be the active process of directing, guiding, and influencing the outcome of an individual's performance of a task. Similarly, NCSBN defines supervision as the provision of guidance or direction, oversight, evaluation and follow-up by the licensed nurse for the accomplishment of a delegated nursing task by assistive personnel. Individuals

supervision, but both have to do with the physical presence and immediate availability of the supervising nurse. The ANA refers to off-site supervision, and NCSBN refers to indirect supervision. Both have to do with availability of the supervising nurse through various means of written and verbal communication.

III. Policy Considerations

- State nurse practice acts define the legal parameters for nursing practice. Most states authorize RNs to delegate.
- There is a need and a place for competent, appropriately supervised nursing assistive personnel in the delivery of affordable, quality health care.
- The RN assigns or delegates tasks based on the needs and condition of the patient, potential for harm, stability of the patient's condition, complexity of the task, predictability of the outcomes, abilities of the staff to whom the task is delegated, and the context of other patient needs.
- All decisions related to delegation and assignment are based on the fundamental principles of protection of the health, safety and welfare of the public.

IV. Principles of Delegation

- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN may delegate components of care but does not delegate the nursing process itself. The practice pervasive functions of assessment, planning, evaluation and nursing judgment cannot be delegated.
- The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence, experience and facility/agency policies and procedures.
- The RN individualizes communication regarding the delegation to the nursing assistive personnel and client situation and the communication should be clear, concise, correct and complete. The RN verifies comprehension with the nursing

engaging in supervision of patient care should not be construed to be managerial supervisors on behalf of the employer under federal labor law.

assistive personnel and that the assistant accepts the delegation and the responsibility that accompanies it.

- Communication must be a two-way process. Nursing assistive personnel should have the opportunity to ask questions and/or for clarification of expectations.
- The RN uses critical thinking and professional judgment when following the Five Rights of Delegation, to be sure that the delegation or assignment is:
 1. The right task
 2. Under the right circumstances
 3. To the right person
 4. With the right directions and communication; and
 5. Under the right supervision and evaluation.
- Chief Nursing Officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation.
- There is both individual accountability and organizational accountability for delegation. Organizational accountability for delegation relates to providing sufficient resources, including:
 - Sufficient staffing with an appropriate staff mix
 - Documenting competencies for all staff providing direct patient care and for ensuring that the
- RN has access to competence information for the staff to whom the RN is delegating care of. Organizational policies on delegation are developed with the active participation of all nurses, and acknowledge that delegation is a professional right and responsibility.

V. Delegation Resources

Both the ANA and NCSBN have developed resources to support the nurse in making decisions related to delegation. Appendix A of this paper provides the ANA Principles of Delegation. Appendix B presents the NCSBN decision tree on delegation that reflects the four phases of the delegation process articulated by the NCSBN.

VI. Delegation in Nursing Education

Both the ANA and the NCSBN acknowledge that delegation is a skill that must be taught and practiced for nurses to be proficient in using it in the delivery of nursing care. Nursing schools should provide students with both didactic content and the opportunity to apply theory in a simulated and realistic context. Nursing curricula must include competencies related to delegation. RNs are educated and mentored on how to delegate

and supervise others. The effective use of delegation requires a nurse to have a body of practice experience and the authority to implement the delegation.

A. Delegation **in NCLEX®**

The *NCLEX-RN® Examination Test Plan* includes competencies related to delegation.

Delegation in the Provision of Nursing Care

The ANA paper outlines some basic elements for the nurse that is essential to form the foundation for delegation, including:

1. Emphasis on professional nursing practice;
2. Definition of delegation, based on the nurse practice act and rules/regulations;
3. Review of specific sections of the law and regulations regarding delegation;
4. Emphasis on tasks/functions that cannot be delegated or cannot be routinely delegated;
5. Focus on RN judgment for task analysis and the decision whether or not to delegate.
6. Determination of the degree of supervision required for delegation;
7. Identification of guidelines for lowering risk related to delegation;
8. Development of feedback mechanisms to ensure that a delegated task is completed and to receive updated data to evaluate the outcome.

The NCSBN paper discusses these elements as part of the preparation to delegate. The NCSBN paper also articulates the following steps of the delegation process:

- Assess and plan the delegation, based on the patient needs and available resources.
- Communicate directions to the delegate including any unique patient requirements and characteristics as well as clear expectations regarding what to do, what to report, and when to ask for assistance.
- Surveillance and supervision of the delegation, including the level of supervision needed for the particular situation and the implementation of that supervision, including follow-up to problems or a changing situation.
- Evaluation and feedback to consider the effectiveness of the delegation, including any need to adjust the plan of care.

Delegation skills are developed over time. Nursing employers need to recognize that a newly licensed nurse is a novice who is still acquiring foundational knowledge and skills.

In addition, many nurses lack the knowledge, the skill and the confidence to delegate effectively, so ongoing opportunities to enforce the theory and apply the principles of delegation is an essential part of employment orientation and staff development.

Many nurses are reluctant to delegate. This is reflected in NCSBN research findings and a review of the literature as well as anecdotal accounts from nursing students and practicing nurses. There are many contributing factors, ranging from not having had educational opportunities to learn how to work with others effectively to not knowing the skill level and abilities of nursing assistive personnel to simply the work pace and turnover of patients. At the same time, NCSBN research shows an increase in the complexity of the nursing tasks performed by assistive personnel. With the demographic changes and resultant increase in the need for nursing services, plus the nursing shortage, nurses need the support of nursing assistive personnel.

VII. Conclusions

The topic of delegation has never been timelier. Delegation is a process that, used appropriately, can result in safe and effective nursing care. Delegation can free the nurse for attending more complex patient care needs, develop the skills of nursing assistive personnel and promote cost containment for the healthcare organization. The RN determines appropriate nursing practice by using nursing knowledge, professional judgment and the legal authority to practice nursing. RNs must know the context of their practice, including the state nurse practice act and professional standards as well as the facility/organization's policies and procedures related to delegation. Facing a shortage of epic proportions, the nursing community needs to plan how we can continue to accomplish nursing care while assuring the public access to safe, competent nursing care. RNs are urged to seek guidance and appropriate direction from supervisors or mentors when considering decisions about delegation. Mastering the skill and art of delegation is a critical step on the pathway to nursing excellence.

Attachments:

Attachment A: *ANA Principles of Delegation*

Attachment B: *NCSBN Decision Tree – Delegation to Nursing Assistive Personnel*

AMERICAN NURSES ASSOCIATION PRINCIPLES FOR DELEGATION

The following principles have remained constant since the early 1950s.

Overarching Principles:

- The nursing profession determines the scope of nursing practice.
- The nursing profession defines and supervises the education, training and utilization for any assistant roles involved in providing direct patient care.
- The RN takes responsibility and accountability for the provision of nursing practice.
- The RN directs care and determines the appropriate utilization of any assistant involved in providing direct patient care.
- The RN accepts aid from nursing assistive personnel in providing direct patient care.

Nurse-related Principles:

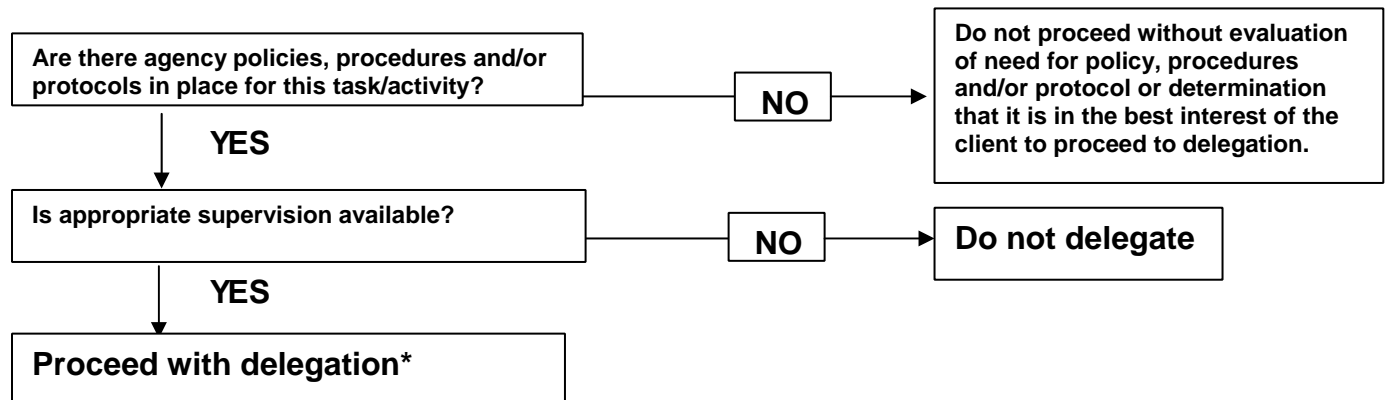
- The RN may delegate elements of care but does not delegate the nursing process itself.
- The RN has the duty to answer for personal actions relating to the nursing process.
- The RN takes into account the knowledge and skills of any individual to whom the RN may delegate elements of care.
- The decision of whether or not to delegate or assign is based upon the RN's judgment concerning the condition of the patient, the competence of all members of the nursing team and the degree of supervision that will be required of the RN if a task is delegated.
- The RN delegates only those tasks for which she or he believes the other health care worker has the knowledge and skill to perform, taking into consideration training, cultural competence experience and facility/agency policies and procedures.
- The RN uses critical thinking and professional judgment when following *The Five Rights of Delegation*:
 1. Right task
 2. Right circumstances
 3. Right person
 4. Right directions and communication
 5. Right supervision and evaluation (NCSBN 1995)
- The RN acknowledges that there is a relational aspect to delegation and that communication is culturally appropriate and the person receiving the communication is treated respectfully.
- Chief nursing officers are accountable for establishing systems to assess, monitor, verify and communicate ongoing competence requirements in areas related to delegation, both for RNs and delegates.

- RNs monitor organizational policies, procedures and position descriptions to ensure there is no violation of the nurse practice act, working with the state board of nursing if necessary.

Organization-related Principles:

- The organization is accountable for delegation through the allocation of resources to ensure sufficient staffing so that the RN can delegate appropriately.
- The organization is accountable for documenting competencies for all staff providing direct patient care and for ensuring that the RN has access to competency information for staff to whom the RN is delegating patient care.
- Organizational policies on delegation are developed with the active participation of all nurses (staff, managers and administrators).
- The organization ensures that the education needs of nursing assistive personnel are met through the implementation of a system that allows for nurse input.
- Organizations have policies in place that allow input from nurses indicating that delegation is a professional right and responsibility.

Step One – Assessment and Planning



Step Two – Communication

Communication must be a two-way process

The nurse:	The nursing assistive personnel:	Documentation:
<ul style="list-style-type: none"> Assesses the assistant's understanding of how the task is to be accomplished When and what information is to be reported, including Expected observations to report and record Specific client concerns that would require prompt reporting. Individualizes for the nursing assistive personnel and client situation Addresses any unique client requirements and characteristics, and clear expectations of: Assesses the assistant's understanding of expectations, providing clarification if needed. Communicates his or her willingness and availability to guide and support assistant. Assures appropriate accountability by verifying that the receiving person accepts the delegation and accompanying responsibility 	<ul style="list-style-type: none"> Ask questions regarding the delegation and seek clarification of expectations if needed Inform the nurse if the assistant has not done a task/function/activity before, or has only done infrequently Ask for additional training or supervision Affirm understanding of expectations Determine the communication method between the nurse and the assistive personnel Determine the communication and plan of action in emergency situations. 	<p><i>Timely, complete and accurate documentation of provided care</i></p> <ul style="list-style-type: none"> Facilitates communication with other members of the healthcare team Records the nursing care provided.

Step Three – Surveillance and Supervision

The purpose of surveillance and monitoring is related to nurse's responsibility for client care within the context of a client population. The nurse supervises the delegation by monitoring the performance of the task or function and assures compliance with standards of practice, policies and procedures. Frequency, level and nature of monitoring vary with needs of client and experience of assistant.

<p>The nurse considers the:</p> <ul style="list-style-type: none"> ▪ Client's health care status and stability of condition ▪ Predictability of responses and risks ▪ Setting where care occurs ▪ Availability of resources and support infrastructure. ▪ <u>Complexity of the task being performed.</u> 	<p>The nurse determines the frequency of on-site supervision and assessment based on:</p> <ul style="list-style-type: none"> ▪ Needs of the client ▪ Complexity of the delegated ▪ function/task/activity ▪ Proximity of nurse's location 	<p>The nurse is responsible for:</p> <ul style="list-style-type: none"> ▪ Timely intervening and follow-up on problems and concerns. Examples of the need for intervening include: ▪ Alertness to subtle signs and symptoms (which allows nurse and assistant to be proactive, before a client's condition deteriorates significantly). ▪ Awareness of assistant's difficulties in completing delegated activities. ▪ Providing adequate follow-up to problems and/or changing situations is a critical aspect of delegation.
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Step Four – Evaluation and Feedback

Evaluation is often the forgotten step in delegation.

<ul style="list-style-type: none"> ○ In considering the effectiveness of delegation, the nurse addresses the following questions: ○ Was the delegation successful? ○ Was the task/function/activity performed correctly? ○ Was the client's desired and/or expected outcome achieved? ○ Was the outcome optimal, satisfactory or unsatisfactory? ○ Was communication timely and effective? ○ What went well; what was challenging? ○ Were there any problems or concerns; if so, how were they addressed? ○ Is there a better way to meet the client need? ○ Is there a need to adjust the overall plan of care, or should this approach be continued? ○ Were there any "learning moments" for the assistant and/or the nurse? ○ Was appropriate feedback provided to the assistant regarding the performance of the delegation? ○ Was the assistant acknowledged for accomplishing the task/activity/function?
--

APPENDIX 4E: SEIZURE ACTION PLAN



Seizure Action Plan

Effective Date _____

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____	Date of Birth _____
Parent/Guardian _____	Phone _____ Cell _____
Other Emergency Contact _____	Phone _____ Cell _____
Treating Physician _____	Phone _____
Significant Medical History _____	

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

Basic First Aid: Care & Comfort

Please describe basic first aid procedures: _____

Does student need to leave the classroom after a seizure? ☐ Yes ☐ No

If YES, describe process for returning student to classroom: _____

Emergency Response

A "seizure emergency" for this student is defined as: _____

Seizure Emergency Protocol

(Check all that apply and clarify below)

- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications as indicated below
- ☐ Notify doctor
- ☐ Other _____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use: _____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: _____

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

DPC772

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APPENDIX 5
ADVERSE EVENT REPORT

APPENDIX 5A: P&P 2.05 MANDATORY REPORTING OF ABUSE AND NEGLECT



STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. BOX 3378
HONOLULU, HI 96801-3378

DEVELOPMENTAL DISABILITIES DIVISION

TITLE: Mandatory Reporting of Abuse and Neglect

Policy #2.05

PURPOSE To protect, to the extent possible, the health, safety, and well-being of the people that the Developmental Disabilities Division (DDD) serves, and be compliant with state laws on reporting abuse and neglect of vulnerable adults and children by reporting abuse, exploitation, financial exploitation, neglect and self-neglect to proper authorities according to state law.

SCOPE This policy (#2.05) applies to suspected victims of abuse and neglect who are not receiving waiver services. Suspected cases of abuse and neglect for participants receiving Medicaid Waiver Home and Community Based Services (HCBS) should follow DD Policy 3.07 "Adverse Events Reports for DDD Participants."

DEFINITIONS

Definitions can be found at the following links:

1. Adult abuse or neglect statutory definitions:
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm
2. Child abuse or neglect statutory definitions:
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm

POLICY DDD employees who in the performance of their professional or official duties, know or have reason to believe that a child or vulnerable adult has been abused or is in danger of abuse if immediate action is not taken promptly, shall report this matter promptly and appropriately to the Department of Human Services (DHS) Child Welfare Services (CWS) or Adult Protective Services (APS). The mandate to report abuse and neglect applies to all DDD employees who are licensed or registered in a health or health-related occupation and who examines, attends,

DDD Policy Manual

Page 1

Effective Date: **MAR - 8 2016**
Revised Date(s):

treats, or provides other professional or specialized services to a vulnerable adult. This includes social workers who are licensed by the State of Hawaii and non-licensed persons employed in social worker positions. State statutes does not prohibit any person from reporting an incident of abuse and neglect that is brought to a DDD employees' attention in a private or non-professional capacity.

PROCEDURES

- A. Suspected abuse of a vulnerable adult.** When a DDD employee, who in his/her professional or official capacity has reason to believe a vulnerable adult has been the victim of abuse or neglect or has a substantial risk of this occurring in the reasonably near future:
1. Shall inform employee's immediate supervisor or DDD designee to ensure DDD policies and procedures are followed;
 2. Shall immediately orally report instances of suspected abuse, or at risk of abuse if immediate action is not taken, to the Department of Human Services (DHS), Adult Protective Services (APS) and/or the Honolulu Police Department, as appropriate. (APS contact information can be found on: <http://humanservices.hawaii.gov/ssd/home/adult-services/>).
 3. Shall document his/her oral report of abuse to APS, in writing, by completing the attached APS "Report Form for Adult Abuse and Neglect" on the day of or at the latest the next business day of suspected abuse and neglect. Follow the directions on the APS report form to fax or mail the form to the appropriate APS office where the verbal report was made. A copy of the completed report form should then be submitted to his/her immediate supervisor for filing.
 4. As a courtesy and upon the discretion of the DDD employee/supervisor, if the vulnerable adult was living in a residence licensed by the Office of Health Care Assurance (OHCA), the employee may report the matter to OHCA.
- B. Suspected abuse of a child under age 18 years old.** The DDD employee, who in the employee's professional or official capacity has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the foreseeable future:
1. Shall inform the employee's immediate supervisor or DDD designee of disclosure and ensure DDD policies and procedures are followed;
 2. Shall immediately orally report the case to DHS, Child Welfare Services (CWS) or the Honolulu Police Department. (CWS contact information can be found on: <http://humanservices.hawaii.gov/ssd/home/child-welfare-services/>);
 3. Shall document his/her oral report of abuse to CWS, in writing, by completing the attached CWS "Mandated Reporter Checklist for Suspected Child Abuse & Neglect" on the day of or on the latest the next business day of suspected abuse and neglect. Follow directions on the CWS report form to fax or mail the report form to the appropriate CWS office. A copy of the completed report form should then be submitted to his/her immediate supervisor for filing.

- C. DDD employees shall refer to DOH Health Insurance Portability & Accountability Act (HIPAA) Policy 3.03 on "Uses and disclosures of Protected Health Information (PHI) about victims of abuse, neglect or domestic violence," and DDD Policies & Procedures 3.03 on "Uses and disclosures of PHI for Victims of Abuse, Neglect or Domestic Violence" for guidance on disclosures of information on alleged incidences of abuse and neglect.**

AUTHORITATIVE & OTHER REFERENCES:

1. §346-222, HRS (Definitions of Vulnerable Adult Abuse)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0222.htm;
2. §346-224, HRS, (Mandatory reporting of vulnerable adult abuse and neglect)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0346/HRS_0346-0224.htm;
3. §350-1, HRS, (Definitions of Child Abuse)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001.htm;
4. §350-1.1, HRS (Mandatory reporting of child abuse and neglect)
http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0350/HRS_0350-0001_0001.htm;
5. Department of Human Services, CWS "A Guide for Mandated Reporters"
<http://humanservices.hawaii.gov/ssd/files/2013/01/MANDATED-REPORTER-HANDBOOK.pdf>;
6. Department of Health & Human Services, APS and Executive Office on Aging "Guidelines for Mandated Reporters Vulnerable Adult Abuse & Neglect"
<http://humanservices.hawaii.gov/ssd/files/2013/01/APS-Guidelines.pdf>;
7. Director of Health's "DDD Directive to Report Adult Abuse" dated 08-29-11;
8. HIPAA "Uses and disclosures of PHI about victims of abuse, neglect or domestic violence", "DOH Policy 03.03, March 17, 2008;
9. DDD Policies & Procedures 3.03 on "Uses and disclosures of PHI for Victims of Abuse, Neglect or Domestic Violence."

ATTACHMENTS:

1. APS "Report Form for Adult Abuse and Neglect;"
2. CWS "Mandated Reporter Checklist for Suspected Child Abuse and Neglect."

Approved: _____


Administrator,
Developmental Disabilities Division

Date: March 8, 2016

State of Hawaii
DEPARTMENT OF HUMAN SERVICES
Adult Protective Services

REPORT FORM FOR ADULT ABUSE AND NEGLECT
(Chapter 346, Part X, HRS)
Mail or Fax to APS

ALLEGED VICTIM(S):

Date of Incident: _____

Name(s): _____ Sex _____ Birthdate: _____

Street Address: _____

Mailing Address: _____

ALLEGED PERPETRATOR(S): Identify facility if applicable

Relation to victim: _____

Name(s): _____ Sex: _____ Birthdate: _____

Street Address: _____

Mailing Address: _____

DESCRIBE NATURE AND EXTENT OF INJURY OR HARM AND WHY REPORTER HAS REASON TO BELIEVE THE INCIDENT IS ABUSE, NEGLECT, OR EXPLOITATION:

ACTION TAKEN BY REPORTER TO HELP VICTIM:

Will you continue to provide services to the victim? Yes _____ No _____

Anonymity requested? Yes _____ No _____

Name of Reporter and Facility, if applicable Telephone _____

Address of Reporter/Facility Date _____

DHS 1640 (Rev. 7/09) Destroy superseded form in stock

**DEPARTMENT OF HUMAN SERVICES
ADULT PROTECTIVE SERVICES**

MAIL or FAX the written report to the **Adult Protective Services Office** where you called to make the verbal report.

Oahu:

420 Waiakamilo Rd. #202
Honolulu, HI 96817
Phone: 832-5115 FAX: 832-5391

East Hawaii:

(Hilo/Hamakua/Puna)
1055 Kinoole Street Suite 200
Hilo, HI 96720
Phone: 933-8820 FAX: 969-4917

Maui/Lanai:

1773-B Wili Pa Loop
Wailuku, HI 96793
Phone: 243-5151 FAX: 243-5166

Kauai:

4370 Kukui Grove St., #203
Lihue, HI 96766
Phone: 241-3337 FAX: 241-3476

West Hawaii:

(Kona/Kohala/Kamuela/Kau)
75-5995 Kuakini Hwy. #433
Kailua-Kona, HI 96740
Phone: 327-6280 FAX: 327-6292

Molokai:

General Delivery
P. O. Box 1657
Kaunakakai, HI 96748
Phone: 553-1763 FAX: 553-1764

Indicators of Possible Adult Abuse

The following indicators do not always mean abuse or neglect has occurred, but they can be clues to the need for an abuse investigation. The physical assessment of abuse should be done by a physician or trained health practitioner.

Physical Indicators

- Bruises, welts, discoloration, swelling
- Cuts, lacerations, puncture wounds
- Pale appearance
- Sunken eyes, hollow cheeks
- Pain or tenderness on touching
- Detached retina
- Soiled clothing or bed
- Absence of hair/ bleeding scalp
- Dehydration/malnourishment
- Evidence of inadequate care (e.g., untended bed sores, poor skin hygiene)
- Evidence of inadequate or inappropriate administration of medication
- Burns: may be caused by cigarettes, flames, acids, or friction from ropes
- Signs of confinement (tied to furniture, bathroom fixtures, locked in a room)
- Lack of bandages on injuries or stitches when indicated, or evidence of unset bones

Injuries are sometimes hidden under breasts or on other areas of the body normally covered by clothing. Repeated skin or other bodily injuries should be noted and careful attention paid to their location and treatment. Frequent use of the emergency room, and/or healthcare "shopping" may also indicate physical abuse. The lack of necessary appliances such as walkers, canes, bedside commodes; lack of necessities such as heat, food, water, and unsafe conditions in the home (e.g., no railing on stairs) may indicate abuse or neglect.

Behavioral Indicators from the Victim

These behaviors in themselves, of course, do not indicate abuse or neglect. However, they may be clues to ask more questions and look beyond the obvious.

- Fear
- Withdrawal
- Depression
- Helplessness
- Resignation
- Anger
- Ambivalence/contradictory statements not due to mental dysfunction
- Conflicting accounts of incidents by the family, supporters, victim
- Implausible stories
- Confusion or disorientation
- Non-responsiveness
- Agitation, anxiety
- Hesitation to talk openly

Indicators from the Family/Caregiver

- Elder or vulnerable adult not given the opportunity to speak for self or to see others without the presence of the caregiver (suspected abuser)
- Absence of assistance, indifference or anger toward the vulnerable person
- Family member or caregiver "blames" the elder or vulnerable adult (e.g., accusation that incontinence is a deliberate act)
- Aggression (threats, insults, harassment)
- Previous history of abuse to others
- Social isolation of family or isolation or restriction of activity of the elder or vulnerable adult within the family unit
- Reluctance to cooperate with service providers in planning for care

Indicators of Possible Financial Abuse

- Activity in bank accounts that is inappropriate to the person, e.g., withdrawals from automated banking machines when the person cannot walk or get to the bank
- Unusual interest about the amount of money being expended for the care of the person
- Refusal to spend money on the care of the person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills
- Checks and other document signed when the persons cannot write
- Missing clothing, jewelry, or other items
- Recent will when the person is clearly incapable of making a will
- Recent change of title of house in favor of a "friend" when the person is incapable of understanding the nature of the transaction
- Power of attorney given when person is unable to comprehend the financial situation, and is incompetent to grant power of attorney
- Lack of personal grooming items, appropriate clothing, etc., when the person's income appears adequate to cover such need

Source: Elder and Dependent Adult Abuse Reporting, A Guide for the Mandated Reporter, Community and Senior Services of Los Angeles County, Rev. June 2001; adapted from "Protocols" Consortium for Elder Abuse Prevention, Institute on Aging 3330 Geary Boulevard, 2nd Floor, San Francisco, CA 94118.

LINDA LINGLE
GOVERNOR



LILLIAN B. KOLLER, ESQ
DIRECTOR
HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

**MANDATED REPORTER CHECKLIST
FOR SUSPECTED CHILD ABUSE AND NEGLECT**

When reporting to Child Welfare Services (CWS), Child Protective Services (CPS) please:

1. Review available records.
2. Fill out the checklist as completely as possible using Y for yes, N for no. Leave blank if unknown, unless otherwise indicated.
3. Call the **CWS Intake Reporting Line at (808) 832-5300** or toll free for neighbor islands at **1-800-494-3991** to report your findings.
4. FAX or Mail this document with comments within 5 days to CWS after verbally reporting to the intake worker. **Doing so fulfills your statutory obligation under Chapter 350-1.1(c), Hawaii Revised Statutes, which requires a report in writing as well as the oral report.**
5. If your referral is accepted for investigation, you will be contacted with the disposition.

To:

**Child Welfare Services
420 Waiakamilo Road, Suite 300A
Honolulu, HI 96817-4941**

**Reporting Line: (808) 832-5300 Toll Free Neighbor Islands: 1-800-494-3991
FAX: (808) 832-5292 Toll Free FAX: 1-800-399-1614**

Oral report made to:

Name of Intake Worker: _____ Date/time of report: _____ / _____

Police Report # _____ Officer Assigned (If applicable) : _____

FROM: (Name, Agency and Address of Reporter)	
Name/Agency:	
Address:	Telephone:

ALLEGED VICTIM/S:				
Name	DOB	AGE	School/Grade/SPED	Home Address
1.				
2.				
3.				

CAREGIVER/S: (Circle where applicable)							
FATHER	MOTHER	GUARDIAN	OTHER	FATHER	MOTHER	GUARDIAN	OTHER
Name:		DOB/Age		Name:		DOB/Age	
Address:				Address:			
Employment/Phone				Employment/Phone			
Home Telephone:		Military/Branch of Service		Home Telephone:		Military/Branch of Service	

DHS 1516 (exp. 04/03)(CWI Revised 04/04)

ALLEGED MALTREATER/S:	
Name:	Name:
Address:	Address:
Telephone:	Telephone:
Relationship to victim:	Relationship to victim:

Please list other family members (siblings, others living in home, significant kin, etc.)		
Name	DOB	Relationship to Victim
1.		
2.		
3.		
4.		
5.		
6.		

FACTORS

1. Location and address of child: (at time of report, please check appropriate block and provide address)

<input type="checkbox"/> School	<input type="checkbox"/> Office
<input type="checkbox"/> Home	<input type="checkbox"/> Other: (Specify)
Address:	
Contact tel:	

2. Type of harm:

<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Threatened physical abuse
<input type="checkbox"/> Sexual abuse	<input type="checkbox"/> Threatened sexual abuse
<input type="checkbox"/> Physical neglect	<input type="checkbox"/> Threatened physical neglect
<input type="checkbox"/> Psychological/emotional abuse	<input type="checkbox"/> Threatened psychological harm

3. Evidence of harm:

A. Physical:

<input type="checkbox"/> a	<input type="checkbox"/> Bruising, bleeding	<input type="checkbox"/> i	<input type="checkbox"/> Subdural hematoma (per medical diagnosis)
<input type="checkbox"/> b	<input type="checkbox"/> Injury causing substantial bleeding	<input type="checkbox"/> j	<input type="checkbox"/> Soft tissue swelling
<input type="checkbox"/> c	<input type="checkbox"/> Malnutrition	<input type="checkbox"/> k	<input type="checkbox"/> Extreme pain
<input type="checkbox"/> d	<input type="checkbox"/> Failure to thrive	<input type="checkbox"/> l	<input type="checkbox"/> Extreme impairment in child's functioning
<input type="checkbox"/> e	<input type="checkbox"/> Burns	<input type="checkbox"/> m	<input type="checkbox"/> Gross degradation (child's clothing, appearance)
<input type="checkbox"/> f	<input type="checkbox"/> Poisoning	<input type="checkbox"/> n	<input type="checkbox"/> Physical or medical evidence of sexual abuse
<input type="checkbox"/> g	<input type="checkbox"/> Any fracture	<input type="checkbox"/> o	<input type="checkbox"/> Failure to provide adequate care or supervision
<input type="checkbox"/> h	<input type="checkbox"/> Intentional drugging	<input type="checkbox"/> p	<input type="checkbox"/> Other

B. Behavioral: (Has the child demonstrated any of the following behaviors?)

<input type="checkbox"/> a	<input type="checkbox"/> Frequently tardy or absent from school	<input type="checkbox"/> g	<input type="checkbox"/> Seductive behaviors
<input type="checkbox"/> b	<input type="checkbox"/> Assaults or aggression toward others	<input type="checkbox"/> h	<input type="checkbox"/> Runaways
<input type="checkbox"/> c	<input type="checkbox"/> Withdrawal or depression	<input type="checkbox"/> i	<input type="checkbox"/> Status offenses or law violation
<input type="checkbox"/> d	<input type="checkbox"/> Self mutilation	<input type="checkbox"/> j	<input type="checkbox"/> Suicidal ideation
<input type="checkbox"/> e	<input type="checkbox"/> Chronic depression	<input type="checkbox"/> k	<input type="checkbox"/> Suicide attempts
<input type="checkbox"/> f	<input type="checkbox"/> Inappropriate sexual knowledge	<input type="checkbox"/> l	<input type="checkbox"/> Other

DHS 1516 (exp. 04/03)(CWI Revised 04/04)

4. Please describe briefly what happened. Include what the child said and to whom. Include date/time (or approximate month/year) and location of incident.

5. What immediate action do you believe needs to be taken? Briefly comment:

6. Frequency and intensity of harm, if known by reporter:

<input type="checkbox"/> Single incident	<input type="checkbox"/> Occurs several times/year, escalating harm
<input type="checkbox"/> Infrequent incidents, no escalation of harm	<input type="checkbox"/> Chronic and serious, ongoing pattern of harm

7. Duration of harm, if known by reporter:

<input type="checkbox"/> No history of harm, no previous incidents	<input type="checkbox"/> Harm occurs repeatedly over a period of one year
<input type="checkbox"/> Short duration of harm, less than one month	<input type="checkbox"/> Harm is chronic

8. Is the reporter aware of any prior reports to CWS involving the child or family?

9. Has the victim expressed any of the following:

a	<input type="checkbox"/> Fear of caretaker	e	<input type="checkbox"/> The victim's sibling/s have also been harmed
b	<input type="checkbox"/> Fear of returning to the family home	f	<input type="checkbox"/> The harm occurs frequently (self or other)
c	<input type="checkbox"/> Afraid of being harmed again	g	<input type="checkbox"/> The harm has gotten worse
d	<input type="checkbox"/> Harm was reported harm to friend	h	<input type="checkbox"/> Other

10. Additional concerns regarding the child's health? Explain:

- a. ☐ Mental: _____
- b. ☐ Physical: _____

SERVICES/TREATMENT HISTORY

11. Has the family participated in any service or treatment prior to the report of harm such as:

a	<input type="checkbox"/> Parenting classes	f	<input type="checkbox"/> Substance abuse treatment (specify below)
b	<input type="checkbox"/> Family violence services	g	<input type="checkbox"/> 1. Inpatient
c	<input type="checkbox"/> Educational programs		<input type="checkbox"/> 2. Outpatient
d	<input type="checkbox"/> Individual counseling	h	<input type="checkbox"/> Other: Specify below
e	<input type="checkbox"/> Home visitation		

12. Was the family offered or referred to any of the following services: (Please note choices listed below)
(Yes, No, Unknown, or Declined)

a	<input type="checkbox"/> Substance abuse treatment	f	<input type="checkbox"/> Substance abuse counseling
b	<input type="checkbox"/> Intensive homebased counseling services	g	<input type="checkbox"/> In-home services (outreach, home visiting, etc.)
c	<input type="checkbox"/> Individual counseling or therapy	h	<input type="checkbox"/> Parenting classes
d	<input type="checkbox"/> Anger management	i	<input type="checkbox"/> Other: Specify below
e	<input type="checkbox"/> Public Health Nursing		

DHS 1516 (exp. 04/03)(CWI Revised 04/04)

SUPPORT SYSTEM

13. Support system available to the child and family, willing and able to assist. Including the following:

a	Parents	f	Friends
b	Maternal grandparents	g	Church members
c	Paternal grandparents	h	Community groups
d	Siblings	i	Service providers
e	Other relatives	j	Other: specify below

FAMILY HISTORY

14. Is there a known history of (for mother, father or father figure):

	MOTHER		FATHER/FATHER FIGURE
a	CWS involvement	g	CWS involvement
b	Domestic violence	h	Domestic violence
c	Substance abuse: (Specify)	i	Substance abuse: (Specify)
d	Mental illness	j	Mental illness
e	Victim of abuse	k	Victim of abuse
f	Perpetrator of abuse	l	Perpetrator of abuse

Explain "yes" responses briefly below:

15. May CWS share your identity with the local county police department for follow up? Yes ___ No ___

THANK YOU FOR YOUR ASSISTANCE.

FOR CWS USE ONLY

Disposition: _____

UNIT _____ WORKER _____

ADDITIONAL COMMENTS/NARRATIVE: Please attach comments/narrative if required or necessary for clarification.

APPENDIX 5B: P&P #3.07 ADVERSE EVENT REPORT FOR PEOPLE RECEIVING DEVELOPMENTAL DISABILITIES DIVISION SERVICES

Note: DDD is developing instructions for the new AER form and planning the training for staff and providers. Until training has been completed, please continue to use the current AER form and instructions.

APPENDIX 5C: ADVERSE EVENT REPORT (AER FORM)

State of Hawaii Department of Health Developmental Disabilities Division ADVERSE EVENT REPORT					DDD USE ONLY DATE/TIME RECEIVED																																	
					Date	Time	Met?																															
					Verbal	_____	_____																															
					Written	_____	_____																															
Please Print or Type: <input type="checkbox"/> Waiver Participant <input type="checkbox"/> Non-Waiver Participant					EVENT DATE _____		EVENT TIME _____																															
1. PARTICIPANT NAME (Last, First, Middle Initial) _____				2. SEX _____	3. BIRTHDATE (Month/Day/Year) _____		4. MEDICAID ID # _____	5. UNIT NO. _____																														
6. PROVIDER NAME (Agency/CDPA) _____			7. ISLAND _____	8. CONTACT PERSON _____		9. TELEPHONE NO. _____		10. FAX NO. _____																														
11. PERSON/TITLE REPORTING ADVERSE EVENT (If different from contact person): _____					12. RELATIONSHIP _____																																	
13. SUPERVISOR NAME/DESIGNATED REPRESENTATIVE/TITLE _____																																						
ADVERSE EVENT INFORMATION																																						
SECTION A: GENERAL INFORMATION																																						
14. EVENT LOCATION <input type="checkbox"/> Home <input type="checkbox"/> Foster Home <input type="checkbox"/> DOM Home <input type="checkbox"/> ARCH <input type="checkbox"/> Community <input type="checkbox"/> Program Site <input type="checkbox"/> Other _____																																						
15. PERSON(S) PRESENT: <input type="checkbox"/> Agency Staff <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Other Participants <input type="checkbox"/> CDPA Worker <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____																																						
16. WHO WAS NOTIFIED? (Check all that apply)																																						
<table border="0" style="width: 100%;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 20%;">Date/Time</th> <th style="width: 20%;">Report No. (If applicable)</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Police</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Adult Protective Services (APS)</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Child Protective Services (CPS)</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> DDD Certification Unit</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Office of Health Care Assurance</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Guardian</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Family Member</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Caregiver</td><td>_____</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Other</td><td>_____</td><td>_____</td></tr> </tbody> </table>									Name	Date/Time	Report No. (If applicable)	<input type="checkbox"/> Police	_____	_____	<input type="checkbox"/> Adult Protective Services (APS)	_____	_____	<input type="checkbox"/> Child Protective Services (CPS)	_____	_____	<input type="checkbox"/> DDD Certification Unit	_____	_____	<input type="checkbox"/> Office of Health Care Assurance	_____	_____	<input type="checkbox"/> Guardian	_____	_____	<input type="checkbox"/> Family Member	_____	_____	<input type="checkbox"/> Caregiver	_____	_____	<input type="checkbox"/> Other	_____	_____
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<input type="checkbox"/> Police	_____	_____																																				
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<input type="checkbox"/> Family Member	_____	_____																																				
<input type="checkbox"/> Caregiver	_____	_____																																				
<input type="checkbox"/> Other	_____	_____																																				
17. WHAT WAS DONE? (Check all that apply)																																						
<table border="0" style="width: 100%;"> <thead> <tr> <th style="width: 60%;">Name</th> <th style="width: 20%;">Date/Time</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> No treatment required</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Treated by Agency R.N./L.P.N</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Treated by Other (specify)</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Treated at Emergency Room</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Treated at Physician's Office</td><td>_____</td></tr> <tr><td><input type="checkbox"/> Admitted to hospital</td><td>_____</td></tr> </tbody> </table>									Name	Date/Time	<input type="checkbox"/> No treatment required	_____	<input type="checkbox"/> Treated by Agency R.N./L.P.N	_____	<input type="checkbox"/> Treated by Other (specify)	_____	<input type="checkbox"/> Treated at Emergency Room	_____	<input type="checkbox"/> Treated at Physician's Office	_____	<input type="checkbox"/> Admitted to hospital	_____																
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<input type="checkbox"/> Admitted to hospital	_____																																					
18. SECTION B: DISCOVERY Fully describe the event and potential causes and/or contributory factors (e.g., WHO, WHAT, WHEN and HOW the event occurred and WHY it occurred). Attach additional pages as necessary. _____																																						

DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION
ADVERSE EVENT REPORT

19. SECTION C: NATURE/TYPE OF ADVERSE EVENT BEING REPORTED Check the appropriate box related to the type/nature of adverse event being reported and answer all items under that subsection. Select ONLY ONE as the primary event.

1. SUSPECTED ABUSE/NEGLECT	
Type: <input type="checkbox"/> Physical <input type="checkbox"/> Psychological/Verbal <input type="checkbox"/> Financial <input type="checkbox"/> Neglect <input type="checkbox"/> Sexual	
List of Person(s) present when suspected abuse/neglect occurred	Relationship to Participant
_____	_____
_____	_____
_____	_____
2. INJURY FROM A KNOWN/UNKNOWN CAUSE REQUIRING TREATMENT	
Type: <input type="checkbox"/> Bruise <input type="checkbox"/> Fracture <input type="checkbox"/> Cut <input type="checkbox"/> Sprain <input type="checkbox"/> Other	
Location: <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Stomach	
<input type="checkbox"/> Back <input type="checkbox"/> Arm <input type="checkbox"/> Hand <input type="checkbox"/> Foot <input type="checkbox"/> Leg <input type="checkbox"/> Other (describe: _____)	
Cause: <input type="checkbox"/> Unknown <input type="checkbox"/> Unattended fall <input type="checkbox"/> Attended fall (Identify person) _____	
<input type="checkbox"/> Another person (Identify person) _____	
<input type="checkbox"/> Accident (explain) _____	
<input type="checkbox"/> Other (describe): _____	
3. MEDICATION ERRORS AND/OR UNEXPECTED REACTION TO MEDICATION OR TREATMENT	
<input type="checkbox"/> Unexpected reaction to Medication <input type="checkbox"/> Unexpected Reaction to Treatment	
<input type="checkbox"/> Medication Error <input type="checkbox"/> Adverse <input type="checkbox"/> Non-adverse	
Nature of Medication Error: <input type="checkbox"/> Did not give <input type="checkbox"/> Wrong Dose <input type="checkbox"/> Wrong Time <input type="checkbox"/> Wrong Medication	
<input type="checkbox"/> Other: _____	
Medication: <input type="checkbox"/> Over the counter <input type="checkbox"/> Prescription Drug Name: _____	
4. CHANGE IN PARTICIPANT'S BEHAVIOR (Check all that apply)	
<input type="checkbox"/> New behavior <input type="checkbox"/> Change in behavior	
Nature of Behavior: <input type="checkbox"/> Assaultive <input type="checkbox"/> Threat to Others <input type="checkbox"/> Threat to Self <input type="checkbox"/> Destroying Property	
<input type="checkbox"/> Other: _____	
Behavior Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	
Restraints: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Authorized by physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. CHANGE IN PARTICIPANT'S HEALTH CONDITION REQUIRING MEDICAL TREATMENT	
<input type="checkbox"/> Chest Pain <input type="checkbox"/> Headache <input type="checkbox"/> Seizure <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainted <input type="checkbox"/> Abdominal pain	
<input type="checkbox"/> Skin problem <input type="checkbox"/> Decubitis <input type="checkbox"/> Dental problem	
<input type="checkbox"/> Other: _____	
6. DEATH	
Date of death: _____ Cause of death (if known): _____	
7. PARTICIPANT'S WHEREABOUTS UNKNOWN	
Status: <input type="checkbox"/> Unknown <input type="checkbox"/> Found Length missing: _____	
If found, participant's physical /emotional status (describe): _____	
<input type="checkbox"/> Injury noted <input type="checkbox"/> No injury	

20. SECTION D: REMEDIATION PLAN OF ACTION TO PREVENT REOCCURRENCE OF THE EVENT Attach additional pages as necessary.

<p>_____</p>
<p>AGENCY/REPRESENTATIVE SIGNATURE _____ PRINT NAME _____ DATE _____</p>

DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION
ADVERSE EVENT REPORT

FOR DDD USE ONLY

1. SUMMARY OF ACTION TAKEN BY CASE MANAGER <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																			
2. CASE MANAGER ASSESSMENT <input type="checkbox"/> Appropriate corrective action taken by agency or CDPA in Section D <input type="checkbox"/> Inappropriate corrective action in Section D																			
3. CASE MANAGER PLAN OF ACTION (Complete ONLY if assessment indicates provider agency or CDPA action plan is inappropriate or additional actions by the case manager are warranted. (Include timelines.) <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																			
4. <div style="display: flex; justify-content: space-between;"> <div>CASE MANAGER SIGNATURE _____</div> <div>PRINT NAME _____</div> <div>DATE _____</div> </div>																			
5. SUPERVISOR REVIEW & COMMENTS: <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> CM met timeline for review/assessment? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain if not met. <input type="checkbox"/> CM Assessment appropriate? Yes <input type="checkbox"/> No <input type="checkbox"/> Explain if not appropriate. <input type="checkbox"/> Add'l Follow-up required <input type="checkbox"/> Follow-up date _____ </div> <div style="width: 35%;"></div> </div> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																			
6. <div style="display: flex; justify-content: space-between;"> <div>UNIT SUPERVISOR SIGNATURE _____</div> <div>PRINT NAME _____</div> <div>DATE _____</div> </div>																			
7. FOLLOW-UP ACTION: (Complete ONLY if follow-up was required) Follow-Up Action Completed <input type="checkbox"/> Date: _____ Provide any comments on the follow-up action. If reviewed by Mortality Review Committee, summarize findings here. <div style="border: 1px solid black; height: 50px; width: 100%;"></div>																			
8. DISTRIBUTION: <table style="width: 100%;"> <tr> <td>REPORT SENT TO:</td> <td>DATE:</td> <td></td> <td>DATE:</td> </tr> <tr> <td><input type="checkbox"/> Provider/Designated Rep</td> <td>_____</td> <td><input type="checkbox"/> OHCA</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> DDD-QA</td> <td>_____</td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> DDD Residential Section</td> <td>_____</td> <td></td> <td></td> </tr> </table>				REPORT SENT TO:	DATE:		DATE:	<input type="checkbox"/> Provider/Designated Rep	_____	<input type="checkbox"/> OHCA	_____	<input type="checkbox"/> DDD-QA	_____	<input type="checkbox"/> Other	_____	<input type="checkbox"/> DDD Residential Section	_____		
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<input type="checkbox"/> Provider/Designated Rep	_____	<input type="checkbox"/> OHCA	_____																
<input type="checkbox"/> DDD-QA	_____	<input type="checkbox"/> Other	_____																
<input type="checkbox"/> DDD Residential Section	_____																		

APPENDIX 5D: AER INSTRUCTIONS

Top of form: Select one of the boxes for the participant. If participant is in the I/DD Medicaid waiver, select “waiver participant.” If receiving only state funded services, select “non-waiver participant.”

1. **Participant Name:** Write or enter the applicant’s participant’s name – Last name, First name, M.I. Be sure to use given name and not nicknames.
2. **Sex:** Write or enter the sex of the participant – male or female.
3. **Birthdate:** Write or enter the birthdate of the participant in MM/DD/YYYY. For example, August 30, 2006 shall be entered as 08/30/2006.
4. **Medicaid ID #:** If participant is in the I/DD waiver, write or enter the participant’s 10-digit Medicaid ID #. If participant is not in the I/DD waiver, write or enter “Not applicable.”
5. **Unit No.:** Write or enter the case management unit to which the participant is assigned.
6. **Provider Name (Agency /CDPA):** Write or enter the name of the agency. If the provider is performing a service under the consumer directed program, write or enter the name of the service provider.
7. **Island:** Write or enter the name of the island where the provider agency or CDPA provider delivers the service.
8. **Contact Person:** Write or enter the name of the person who can coordinate or obtain information on the adverse event. This is a person within the provider agency or the CDPA provider.
9. **Telephone No.:** Write or enter the fax number for the contact person.
10. **Fax No.:** Write or enter the fax number for the contact person.
11. **Person/Title Reporting Adverse Event** (if different from contact person): Complete only if different from contact person in #8. Write or enter the name of the person. Enter the last name followed by a comma, then first name followed by a comma, and middle initial (e.g. Smith, John, and K.). Do not use nicknames. Write or enter the person’s title (e.g., direct support worker, case manager, or consumer directed employee).
12. **Relationship:** Write or enter the relationship to the participant (mother, cousin, foster parent, or direct support worker).

- 13. Supervisor Name/Designated Representative/Title:** Write or enter the name of the supervisor of the person reporting the adverse event. In the case of the CDPA worker, enter the participant or his/her representative. Enter the last name followed by a comma, then first name followed by a comma, and middle initial (e.g. Smith, John, and K.). Do not use nicknames. If the person initiating the Adverse Event Report/completing the form does not have a supervisor, enter N/A.
- 14. Event location:** Check the location where the Adverse Event occurred. If adverse event occurred in the participant's residence, indicate the type of residence. Community includes places such as grocery store, park, or workplace and program sites include such places as an Adult Day Health Program, agency community meeting center, or other facility where the participant attends or meets for activities. Specify location if "Other" is checked.
- 15. Person(s) Present:** Check to indicate who was present when the event occurred. If the event was not observed and the participant cannot identify who was present, check "unknown". If "other" is checked, specify the person(s). Examples include, but are not limited to, friend, bus driver, restaurant employee, sister, or father.
- 16. Who Was Notified?** (Check all that apply): Check to indicate the persons or agencies verbally notified in response to the type of event that occurred. For example, if the adverse event is a suspected abuse/neglect, CPS or APS shall be notified for appropriate follow-up/investigation. For all Adverse Events, the case manager shall be notified verbally or by fax within 24 hours or the next business day of an event.
- Enter the name of the person notified, date and the date and time of the notification. If "other" is selected, specify the person contacted. This may include but, is not limited to, participant's physician (i.e. psychiatrist, neurologist, or internist). Date shall be entered in mm/dd/yyyy format. For example, August 30, 2006 shall be entered as 08/30/2006. Time shall be entered as the time followed by a.m. or p.m. For example, four o'clock in the afternoon shall be written as 4:00 p.m.
- 17. What Was Done?:** This refers to what was done in response to the adverse event. Check to indicate what was done in response to the adverse event. If treatment was provided, enter the name of the person or organization (e.g., Queen's Hospital Emergency Room) providing the treatment and the date and time of treatment.
- 18. Section B - Discovery:** Provide a full description of the adverse event, including potential causes and/or contributory factors. The description shall include what occurred (nature/type of adverse event being reported), when it occurred, where it occurred, how it occurred and why it occurred (potential causes and/or contributory factors). The description may include the names of the persons present when event occurred and their involvement. If the participant did not require any type of treatment as a result of the

Adverse Event, describe what actions were taken to assure the participant's safety following the event (e.g. neurologist was contacted and participant was monitored for side effects following the medication error). Attach diagrams, charts, and/or additional pages of description. If additional pages are attached, number pages B-1, B-2, etc.

19. **Section C - Nature/Type of Adverse Event Being Reported:** Check the box that best describes the adverse event and complete the information in that section.
20. **Section D - Remediation Plan of Action to Prevent Reoccurrence of the Event:** The agency supervisor or caregiver provides a plan of action to prevent the reoccurrence of the event. Provide a description of what has been done or will be done to prevent recurrence of the adverse event. For example, if the cause of the event was that the worker did not understand how a task should be done, then describe what was done with this worker (i.e. training, changing policies and procedures, closer supervision and monitoring of the worker(s), etc.). Include timelines for completion and implementation. If additional pages are attached, number the additional pages as D-1, D-2, etc.
21. **Agency/Representative Signature:** The person attesting to the information on the form shall sign and print full name and date.

FOR DOH-DDD USE ONLY

Top of form: When the adverse event is reported (verbally and write) to DOH-DDD, the CM writes the date and time of the report.

- Enter the date in mm/dd/yyyy format. For example, August 30, 2006 shall be entered as 08/30/2006.
- Enter the time the event occurred. Time shall be entered as the time followed by a.m. or p.m. For example, four o'clock in the afternoon shall be written as 4:00 p.m. Do not use the military or 24-hour clock format.
- Determine whether the report met the 24 hour or 72 hours reporting requirement. Enter "Y" if the reporting requirement was met and "N" if the reporting requirement was not met.

1. **Summary of Action Taken by Case Manager:** The Case Manager assesses the information in the Adverse Event Report and determines what follow-up actions, if any, are necessary given the type of Adverse Event. Follow-up actions must include dates of face-to-face contacts, home and site visits, and telephone calls.

2. **Case Manager Assessment:** The Case Manager indicates whether the corrective action taken by the agency or CDPA provider was appropriate. If the corrective action was inappropriate, the case manager will complete the next section/
3. **Case Manager's Plan of Action:** The Case Manager completes if the agency or CDPA provider corrective action was inappropriate. Describe additional actions taken or to be taken to minimize the risk and prevent the reoccurrence of this event. Examples include, but are not limited to, revising the service plan to authorize additional services, reassessment of needs, or obtaining alternative residential placement.
4. **Case Manager Signature:** The Case Manager signs and print his/her name and date.
5. **Supervisor's Comments:** The Supervisor determines whether the case manager's action(s) and assessment were completed within the required timeframe of 5 working days. If so, the Supervisor checks the box for timeline met. If not, write comment on reason and corrective action for the future.

The Supervisor also reviews the case manager's assessment and plan of action, if completed. If the Supervisor concurs with the case manager's assessment and plan of action, the unit supervisor signs and dates the form. If the Supervisor does not concur with the assessment and/or plan of action, the Supervisor writes his/her comments, returns the form to the case manager and discusses the required changes. The Case Manager changes the assessment or plan of action as appropriate. If the changes meet the Supervisor's satisfaction, the Supervisor signs and dates the form.

If the Supervisor determines that additional follow-up date is required, the Supervisor will indicate a follow-up date.

6. **Supervisor Signature:** Supervisor shall sign and print his/her name and date.
7. **Follow-Up Action:** If a follow-up is indicated by the Supervisor, the Case Manager follows-up with the agency or CDPA provider that the corrective action was taken. The Case Manager checks the box that follow-up was completed and notes the date of the follow-up. The Case Manager also notes the action(s) taken in the space provided.

Note: All deaths will be reviewed by the Division's Mortality Review Committee. If the Committee provides recommendation(s) to the agency or CDPA provider, the Case Manager must verify that the recommendation(s) has/have been implemented.

8. **Distribution:** Check the appropriate box and the date it was sent. Be sure to send a copy as the original is filed in the participant's file.

The following describes the timetable:

Provider/Designated Rep: The CM Follow-Up Report must be sent to the reporting agency within five (5) days with the Final report submitted within 2 weeks.

DOH-DDD QA: The Adverse Event Report must be sent to DOH-DDD-QA within three (3) days. Final report shall be submitted within 2 weeks.

DOH-DDD Residential Section: Send for appropriate follow-up by the DOH-DDD Residential Section if the Adverse Event involves an adult foster parent.

Office of Health Care Assurance (OHCA): Send for appropriate follow-up by OHCA if Adverse Event involves a care home operator or DD Domiciliary caregiver.

Other: Specify persons or agencies Adverse Event Report was sent to. This may include POS provider or Consumer Directed Employer.

APPENDIX 6

PARTICIPATION AS A MEDICAID PROVIDER

6A: MEDICAID APPLICATION/CHANGE REQUEST FORM (DHS 1139)

<http://www.med-quest.us/PDFs/Frequently%20Used%20Forms%20for%20Providers/DHS%201139.pdf>

Important Reminder

Send the completed form and \$500 check (payable to State Director of Finance c/o Med-QUEST Division) to:

Community Resources Branch
3627 Kilauea Avenue, Room 411
Honolulu, HI 96816

The Application and Check will first be processed at Community Resource Branch, and then sent to Med-QUEST once approved.

APPENDIX 7

GENERAL STAFF QUALIFICATION REQUIREMENTS

APPENDIX 7A: SPREADSHEET FOR VALIDATION OF NEW AND CURRENT PROVIDER STAFF

Appendix 7A includes two spreadsheets for new employees and current employees. These spreadsheets are tools for the providers to use in preparation for the annual validation of staff that is required in the Medicaid I/DD Waiver. It is recommended that the providers use the spreadsheets for tracking and monitoring all required validation documents and to keep the documents current at all times in order to meet the Medicaid I/DD Waiver Standards.

Provider Staff Credentials - New Employees FY-17														8/21/2017
Agency:														
Name	Position (SSPV RN, DSW)	Date Started Providing Services	Orientation Conducted before Start Date? (Y/N)	Cleanings Submitted before Start Date?	TB 2- step	First Aid	CPR	State Criminal History (CHRI)	APS	CAN	HS Diploma or GED (if hired after July 2017)	Education - BA/ 1 year Experience	RN or Behav. Specialist	Orientation Training Date, 16 Topics covered (Y/N)

1

**Provider Current Staff Credentials
FY-17**

8/21/2017

Agency:

Name	Position (SSPV, RN, DSW)	Date Started Providing Services	TB	First Aid	CPR	State Criminal History	FBI Fingerprinting	APS	CAN- Child Protective Services	Education - BA/ 1 year Experience	RN or Behav. Specialist	Annual Training	Comments
							1st:						
							2nd:						
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APPENDIX 7B: HYPERLINKS TO RESOURCES FOR REQUIRED CLEARANCES

Clearance	Forms, Instructions, Administrative Rules, Standards	Hyperlink Reference
Tuberculosis (TB)	Hawaii Administrative Rules (HAR), Title 11, Department of Health, Chapter 164, Tuberculosis	http://health.hawaii.gov/opppd/files/2015/06/11-164.pdf
Criminal History Record and Background Checks	Department of Human Services Med-QUEST Division, Criminal History Record and Background Check Standards	http://www.med-quest.us/PDFs/Providers/CriminalHistoryRecordCheckStandards.pdf
Criminal History Record and Background Checks	Provider Memo ACS M12-08B re: Criminal History Record and Registry Check Process Update	http://www.med-quest.us/PDFs/Provider%20Memos/ACSMEMO2012/ACS%20M12-08B.pdf
Criminal History Record and Background Checks	Request for Exemption from Criminal History Record and Background Check Standards (Form DHS-1200)	http://www.med-quest.us/PDFs/Providers/DHS1200ExemptionRequestformRev1015.pdf
Criminal History Record and Background Checks	Request for Exemption from Criminal History Record and Background Check Standards Instructions (Form DHS-1200A)	http://www.med-quest.us/PDFs/Providers/DHS1200AExemptionRequestInstructionRev1015.pdf

Criminal History Record and Background Checks	Department of Human Services Med-QUEST Division Procedures for Processing Exemption Requests from the Criminal History Record and Background Check Standards	http://www.med-quest.us/PDFs/Providers/Exemption%20Procedures-%201012.pdf
Criminal History Record and Background Checks	Department of Human Services Med-QUEST Division Criminal History Record and Background Check Standards Checklist for Exemption Request	http://www.med-quest.us/PDFs/Providers/Exemption%20Checklist%20(10-12).pdf
Criminal History Record and Background Checks	Statement of Authenticity	http://www.med-quest.us/PDFs/Providers/StatementOfAuthenticity.pdf
Adult Protective Services (APS)	APS	Protective Services Central Registry Check Standards
Child Abuse and Neglect Registry (CAN)	CAN	Protective Services Central Registry Check Standards

APPENDIX 8

MONITORING PROVIDER AGENCIES

APPENDIX 8A: QA/I PROVIDER MONITORING TOOL

State of Hawaii Department of Health Developmental Disabilities Division		
QUALITY ASSURANCE/IMPROVEMENT REVIEW OF HAWAII'S DD/ID WAIVER PROVIDERS		
Provider/Agency: _____	Date of Review: _____	
Reviewers: _____	Review Period: _____	

Participant Information	Participant Record Met 100% of Waiver Standards (Y or N)
Participant #1: _____	CMU: _____
Participant #2: _____	CMU: _____
Participant #3: _____	CMU: _____
Participant #4: _____	CMU: _____
Participant #5: _____	CMU: _____

Technical Assistance Provided to Agency (Y or N): _____
 If yes, Technical Assistance was provided on the topics listed below:

QA/I Provider Monitoring Tool (Revised 2/22/2016)

1

FOCUS AREA: SERVICE AUTHORIZATION - Individualized Service Plan (ISP) and Individualized Plan (IP) - (Standards 2.5.2 pp. 14-15)					
Provider Agency Name:					
Indicator	Y	N	Findings/Comments	Quality Improvement Action	Provider Response
1a. Is the IP developed based on the goals outlined in the ISP and/or Waiver Action Plan (WAP)? (p. 14)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 1a.		
1b. Is the IP signed by the Participant and/or legal guardian to indicate that the plan is approved? (p. 14)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 1b.		
1c. Do the methods or approaches support the achievement of the desired goals and outcomes identified in the ISP and/or WAP? (p. 14)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 1c.		
1d. Is the direct support worker(s) adequately/appropriately trained prior to the implementation of the IP and supported by documentation of training? (p. 15)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 1d.		
1e. Did the Participant or the Participant's legal or designated representative and the DOH-DDD CM receive copies of the IP within seven (7) calendar days of its initiation and subsequent revisions?			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 1e.		

FOCUS AREA: SERVICE AUTHORIZATION - Individualized Service Plan (ISP) and Individualized Plan (IP) - (Standards 2.5.2 pp. 14-15)				
Provider Agency Name:				
Indicator	Y	N	Findings/Comments	Quality Improvement Action
(p. 15)				Provider Response

FOCUS AREA: Provider Reporting Requirements - Quarterly Report (Standards 3.6, pp. 35-36)					
Provider Agency Name:					
Indicator	Y	N	Findings/Comments	Quality Improvement Action	Provider Response
2a. Is there a quarterly or more frequent report(s) for each waiver service authorized? (p. 35)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 2a.		
2b. Does the report summarize provider progress towards outcomes identified in the IP? (p. 36)			General Comment: Of the xx records reviewed, xx were in compliance with Indicator 2b.		


FOCUS AREA: Provider Requirements - Adverse Event Reporting (Standards 3.4.4.3, pp. 27-28)					
Provider Agency Name:					
Indicator	Y	N	Findings/Comments	Quality Improvement Action	Provider Response
4a. Was there any reportable adverse event during the review period? (p. 27)			General Comment: Of the xx records reviewed, xx records contained a reportable adverse event.		
4b. Was the adverse event reported within the required verbal timeline (within 24 hours)? (p. 27)			General Comment: Of the xx records reviewed, xx records contained a reportable adverse event.		
4b2. Was the adverse event reported within the required written timeline (within 72 hours)? (p. 27)			General Comment: Of the xx records reviewed, xx records contained a reportable adverse event.		
4c. Was there any reportable adverse event that occurred during service delivery that was not reported on the AER form (i.e., progress notes, data collection, supervisory observations, etc.)? (p. 27)			General Comment: Of the xx records reviewed, xx records contained a reportable adverse event.		

FOCUS AREA: Provider Requirements - Behavior Support Requirements (Standards 3.5, pp. 30-35)					
Provider Agency Name:					
Indicator	Y	N	Findings/Comments	Quality Improvement Action	Provider Response
5a. Does the Participant record include a Positive Behavioral Support (PBS) plan? (p. 30)			General Comment: Of the xx records reviewed, xx records contained a Positive Behavioral Support (PBS) plan.		
5b. If there is a behavior support plan, is the plan integrated into the IP and designed to provide a systematic approach to helping the Participant learn new, positive behaviors while reducing undesirable behaviors? (p. 31)			General Comment: Of the xx records reviewed, xx records contained a Positive Behavioral Support (PBS) plan.		
5c. Is there documentation that training was provided by the appropriate staff for all staff responsible for implementing the behavior support plan? (pp. 31, 33)			General Comment: Of the xx records reviewed, xx records contained a Positive Behavioral Support (PBS) plan.		
5d. If there are restraints or time out being used, has the DDD Behavior Support Review Committee (BSRC) been notified? (pp. 34, 35)			General Comment: Of the xx records reviewed, xx records contained a Positive Behavioral Support (PBS) plan.		

FOCUS AREA: Provider Requirements - Training and Consultation (T&C) (Standards 5.13, pp. 104-106)					
Provider Agency Name:					
Indicator	Y	N	Findings/Comments	Quality Improvement Action	Provider Response
6a. Does the Participant record include a Training and Consultation service? (If yes, indicate in the comments section the type of Training and Consultation service) (pp. 104-106)			General Comment: Of the xx records reviewed, xx records included Training and Consultation.		
6b. Is there evidence of service completion for each Training and Consultation provided? (Evidence includes instructions about treatment regimens and other services authorized in the ISP and/or WAP) (pp. 105-106)			General Comment: Of the xx records reviewed, xx records included Training and Consultation.		

[illegible]

APPENDIX 8B: CAP STATUS LETTER FOR SATISFACTORY CAP

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>	 <p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU 96816 HAWAII 96816</p>	<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>
<p>Telephone: 808-733-2135 Fax: 808-733-9841</p>		<p>In reply, please refer to: File:</p>

[Date]

**CAP Status Letter for Satisfactory CAP
Attachment 2**

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

This letter is to inform you of the status of your Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated **[date of QA Review Results letter]** for the review period **[beginning and ending month and year of annual review period]**.

☐ Your Corrective Action Plan was due on _____.
As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached for your convenience. Please complete the "Provider Response" column and submit it by _____.

☒ We received your Corrective Action Plan on **[date CAP received]**.

☐ We reviewed your CAP and need further information/clarification.
Please respond to the issues/concerns below by _____.

Issues/Concerns:

Please fax your response to (808) 733-9841 or you may mail your response (documents must be de-identified of participant information) to:
Community Resource Management Section
Attn: Revised CAP
3627 Kilauea Avenue, #411
Honolulu, Hawaii 96816

[Title. First Name Last Name, Position Title]
[Agency Name]
[Date]
Page 2

- ☒ We reviewed your CAP and it is satisfactory.
- ☐ We received and reviewed the additional information/clarification you submitted to address our issues/concerns with your CAP. Your CAP is now satisfactory.


Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

Community Resource Management Section

c: Monitor, CRMS

APPENDIX 8C: CAP STATUS LETTER FOR UNSATISFACTORY CAP

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>	 <p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU 96816 HAWAII 96816</p>	<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>
<p>Telephone: 808-733-2135 Fax: 808-733-9841</p>		<p>In reply, please refer to: File:</p>

[Date]

**CAP Status Letter for Unsatisfactory CAP
Attachment 3**

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

This letter is to inform you of the status of your Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated **[date of QA Review Results letter]** for the review period **[beginning and ending month and year of annual review period]**.

☐ Your Corrective Action Plan was due on _____.
As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached for your convenience. Please complete the "Provider Response" column and submit it by _____.

☒ We received your Corrective Action Plan on **[date CAP received]**.

☒ We reviewed your CAP and need further information/clarification.
Please respond to the issues/concerns below by **[4 weeks from date of this letter]**.

Issues/Concerns:

[Issues/Concerns Listed Here]

Please fax your response to (808) 733-9841 or you may mail your response (documents must be de-identified of participant information) to:
Community Resource Management Section
Attn: Revised CAP
3627 Kilauea Avenue, #411
Honolulu, Hawaii 96816

[Title. First Name Last Name, Position Title]
[Agency Name]
[Date]
Page 2

- ☐ We reviewed your CAP and it is satisfactory.
- ☐ We received and reviewed the additional information/clarification you submitted to address our issues/concerns with your CAP. Your CAP is now satisfactory.


Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

Community Resource Management Section

c: Monitor, CRMS

APPENDIX 8D: CAP STATUS LETTER WHEN NO CAP RECEIVED

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>	 <p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816</p>	<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>
<p>Telephone: 808-733-2135 Fax: 808-733-9841</p>		<p>In reply, please refer to: File:</p>

[Date]

**CAP Status Letter when No CAP Received
Attachment 4**

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

This letter is to inform you of the status of your Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated **[date of QA Review Results letter]** for the review period **[beginning and ending month and year of annual review period]**.

☒ Your Corrective Action Plan was due on **[deadline date from QA Review Results Letter]**.
As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached for your convenience. Please complete the "Provider Response" column and submit it by **7 days from date of this letter]**.

☐ We received your Corrective Action Plan on _____.

☐ We reviewed your CAP and need further information/clarification.
Please respond to the issues/concerns below by _____.

Issues/Concerns:

Please fax your response to (808) 733-9841 or you may mail your response (documents must be de-identified of participant information) to:
Community Resource Management Section
Attn: Revised CAP
3627 Kilauea Avenue, #411
Honolulu, Hawaii 96816

[Title, First Name Last Name, Position Title]
[Agency Name]
[Date]
Page 2

- ☐ We reviewed your CAP and it is satisfactory.
- ☐ We received and reviewed the additional information/clarification you submitted to address our issues/concerns with your CAP. Your CAP is now satisfactory.


Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

Community Resource Management Section

c: Monitor, CRMS

APPENDIX 8E: CAP STATUS LETTER FOR SATISFACTORY REVISED CAP

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>		<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>
<p>Telephone: 808-733-2122 Fax: 808-733-9841</p>	<p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH 3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816</p>	<p>In reply, please refer to: File:</p>

[Date]

**CAP Status Letter for Satisfactory
Revised CAP
Attachment 5**

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

This letter is to inform you of the status of your Corrective Action Plan (CAP) in response to the Department of Health, Developmental Disabilities Division's (DOH/DDD), Quality Assurance Review report dated **[date of QA Review Results letter]** for the review period **[beginning and ending month and year of annual review period]**.

☐ Your Corrective Action Plan was due on _____.
As of today, we have not received your CAP. Another copy of the Quality Assurance Review report is attached for your convenience. Please complete the "Provider Response" column and submit it by _____.

☐ We received your Corrective Action Plan on _____.

☐ We reviewed your CAP and need further information/clarification.
Please respond to the issues/concerns below by _____.

Issues/Concerns:

Please fax your response to (808) 733-9841 or you may mail your response (documents must be de-identified of participant information) to:
Community Resource Management Section
Attn: Revised CAP
3627 Kilauea Avenue, #411
Honolulu, Hawaii 96816

[Title. First Name Last Name, Position Title]

[Agency Name]

[Date]

Page 2

- ☐ We reviewed your CAP and it is satisfactory.
- ☒ We received and reviewed the additional information/clarification you submitted to address our issues/concerns with your CAP. Your CAP is now satisfactory.


Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you very much for your assistance in this process.

Sincerely,

Community Resource Management Section

c: Monitor, CRMS

APPENDIX 8F: SANCTION NOTICE 1 WHEN NO CAP RECEIVED

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>		<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>	
<p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411 HONOLULU 96819 HAWAII 96819</p>			
<p>Telephone: 808-733-2125 Fax: 808-733-9541</p>		<p>In reply, please refer to: File:</p>	

[Date]

**Sanction Notice 1 when No CAP Received
Attachment 6**

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

RE: Notice of Non-Compliance with the Medicaid Waiver Provider Standards
1st Notice ☒ 2nd Notice ☐

The Department of Health (DOH), Developmental Disabilities Division (DDD), is issuing this notice of non-compliance to your agency due to the following outstanding issues/concerns:

<u>Subject</u>	<u>Date of Correspondence (See Attached)</u>	<u>Days Overdue</u>	<u>Date Notified of Non-Compliance</u>	<u>Final Due Date</u>
[CAP]	[date of QA Review Letter and/or date of Latest CAP Status Letter]	[Number of days from the original deadline of CAP or Revised CAP to the date of this Letter]	[date of this letter]	[2 weeks from date of this letter]

Please find attached documents regarding these issues. Your agency must come into compliance by the final due date listed above. If you cannot come into compliance by the final due date listed above, please contact the Community Resource Management Section by **1 week from date of this letter**.

Please review page 37 of the Medicaid Waiver Provider Standards, revised July 1, 2011, which states:

3.9 Non-Compliance with STANDARDS

1. *If the DOH or the DHS or their designees determine that the PROVIDER has failed to comply with any of the applicable DD/ID Medicaid Waiver Services Program requirements, the DOH or the DHS or their designees shall notify the PROVIDER of such non-compliance.*

[Title. First Name Last Name, Position Title]

[Agency Name]

[Date]

[Page]

2. *If the areas of non-compliance are not corrected within the time specified in the notice or in the accepted plan of correction, the DHS designee may:*
 - a. *Assess the safety and well-being of the PARTICIPANTS and the PROVIDER'S ability to provide services as outlined in the ISP and/or IP;*
 - b. *Initiate action to ensure the health, safety, and well-being of the PARTICIPANTS; and/or*
 - c. *Terminate this Agreement.*

Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your immediate attention to this notice.


Sincerely,

Community Resource Management Section

KN:pk

c: Med-Quest

APPENDIX 8G: NOTICE 2 WHEN NO CAP RECEIVED

<p>DAVID Y. IGE GOVERNOR OF HAWAII</p>		<p>VIRGINIA PRESSLER, M.D. DIRECTOR OF HEALTH</p>	
<p>STATE OF HAWAII DEPARTMENT OF HEALTH DEVELOPMENTAL DISABILITIES DIVISION COMMUNITY RESOURCES BRANCH</p> <p>3627 KILAUEA AVENUE, ROOM 411 HONOLULU, HAWAII 96816</p>			
<p>Telephone: 808-733-2135 Fax: 808-733-9541</p>		<p>In reply, please refer to: File:</p>	

[Date]

Sanction Notice 2 when No CAP Received Attachment 7

[Title, First Name Last Name, Position Title]
[Agency Name]
[Address]
[City], Hawaii [Zip]

Dear [Title, Last Name]:

RE: Notice of Non-Compliance with the Medicaid Waiver Provider Standards
1st Notice ☐ 2nd Notice ☒

The Department of Health (DOH), Developmental Disabilities Division (DDD), is issuing this notice of non-compliance to your agency due to the following outstanding issues/concerns:

<u>Subject</u>	<u>Date of Correspondence (See Attached)</u>	<u>Days Overdue</u>	<u>Date Notified of Non-Compliance</u>	<u>Final Due Date</u>
[CAP]	[date of QA Review Letter and/or date of Latest CAP Status Letter and date of Sanction Notice 1]	[Number of days from the original deadline of CAP or Revised CAP to the date of this Letter]	[date of Sanction Notice 1]	[2 weeks from date of this letter]

Please find attached documents regarding these issues. Your agency must come into compliance by the final due date listed above. If you cannot come into compliance by the final due date listed above, please contact the Community Resource Management Section by **1 week from date of this letter**.

Please review page 37 of the Medicaid Waiver Provider Standards, revised July 1, 2011, which states:

3.9 Non-Compliance with STANDARDS

1. *If the DOH or the DHS or their designees determine that the PROVIDER has failed to comply with any of the applicable DD/ID Medicaid Waiver Services Program requirements, the DOH or the DHS or their designees shall notify the PROVIDER of such non-compliance.*

[Title, First Name Last Name, Position Title]
[Agency Name]
[Date]
[Page]

2. *If the areas of non-compliance are not corrected within the time specified in the notice or in the accepted plan of correction, the DHS designee may:*
 - a. *Assess the safety and well-being of the PARTICIPANTS and the PROVIDER'S ability to provide services as outlined in the ISP and/or IP;*
 - b. *Initiate action to ensure the health, safety, and well-being of the PARTICIPANTS; and/or*
 - c. *Terminate this Agreement.*

Should you have any questions, please call the Community Resource Management Section at (808) 733-2133. Thank you for your immediate attention to this notice.











Sincerely,

Community Resource Management Section















KN: pk
c: Med-Quest









APPENDIX 9
ADULT DAY HEALTH
RESOURCE

APPENDIX 9A: INTEREST INVENTORY

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
HEALTH & FITNESS	 <small>LIKE A LOT</small>	 <small>LIKE SOME</small>	 <small>DON'T LIKE</small>	 <small>DON'T KNOW</small>	
 CYCLING					
 DANCE CLASSES					
 AEROBICS AT THE GYM					
 SWIMMING					
 YOGA					
 SURFING					
PLEASE LIST OTHER HEALTH FITNESS ACTIVITIES YOU LIKE:					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
SPORTS	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
 PING PONG					
 BASKETBALL					
 POOL/ BILLIARDS					
 DARTS					
 BOWLING					
 GOLF					
 FOOTBALL					
 HOCKEY					
 BASEBALL					
 MARTIAL ARTS/ BOXING					











INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity.
	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
ARTS					
 DRAMA/PLAY					
 SINGING					
 MAKING MUSIC					
 WRITING POEMS					
 FASHION/COSMETICS					
 PHOTOGRAPHY					
 PAINTING OR DRAWING					
 MODEL BUILDING					
 WOODWORKING					
 NEEDLEWORK/ CROCHETING					
 POTTERY					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
ACTIVITY AT HOME	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
 GARDENING					
 SEWING					
 COOKING/ BAKING					
 CAR/ MOTORCYCLE REPAIR					
PLEASE LIST OTHER HOME ACTIVITIES YOU LIKE.					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
LEISURE AT HOME	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
 GAMES/ INTERNET					
 TABLE GAMES					
 PUZZLES/ CROSSWORDS					
 COLLECTING					
 TV/ VIDEO					
 READING					
 LISTENING TO MUSIC					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
OUTDOOR INTERESTS	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
 FISHING					
 KAYAKING/ BOATING					
 CLIMBING					
 WALKING/ HIKING					
 GARDENING					
 BIRDWATCHING					
 CAMPING					
 HORSE RIDING					
 PETS					
PLEASE LIST OTHER OUTDOOR ACTIVITIES YOU LIKE.					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
COMMUNITY ENTERTAINMENT					
 CHARITY WALKS					
 TRAVELLING					
 MOVIES					
 SHOPPING					
 MUSEUMS					
 BINGO					
 CONCERTS					

INTEREST INVENTORY					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
SOCIAL ACTIVITIES	 <small>LIKE A LOT</small>	 <small>LIKE SOME</small>	 <small>DON'T LIKE</small>	 <small>DON'T KNOW</small>	
 GOING TO THE BAR					
 EATING OUT					
 SOCIAL/ NIGHT CLUBS					
 VISITING FRIENDS					
 VOLUNTEER WORK					
 CHURCH ACTIVITIES					
PLEASE LIST OTHER SOCIAL ACTIVITIES YOU LIKE.					

INTEREST CHECKLIST					
CATEGORY	DEGREE OF INTEREST				Please tell me how you currently participate in this activity:
	 LIKE A LOT	 LIKE SOME	 DON'T LIKE	 DON'T KNOW	
EDUCATIONAL					
 ANTIQUES					
 SPEECHES/LECTURES					
 ADULT EDUCATION					
 HISTORY					
 SCIENCE					
 POLITICS					
 FOREIGN LANGUAGE					
 FOREIGN CULTURE					
 ARITHMETIC					

APPENDIX 9B: LEVELS OF COMMUNITY INTERACTION

Levels of Community Interaction

Intentionally Building Relationships

LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
<p>Too many of our participants spend their lives like this.</p>	<p>Shopping at the same stores, getting hair cut at the same shop, going to the same bank, eating at a restaurant on the same day every week. These people are service providers and are PAID to be nice to you.</p>	<p>Regular Passive Contact can create an opportunity to become Cooperative Interactions if two things occur.</p> <p>1) the person is viewed in a positive light, for example has a social valued role and</p> <p>2) Has help facilitating the "ASK" through pre-teaching, modeling, scripting.</p>	<p>Cooperative Interactions create an opportunity to become Extended Relationships.</p> <p>When two people who frequently makes plans to spend time together it creates an Extended Relationship.</p>	<p>These are the people that hug us and we hug back.</p>
<p>No contact with non-disabled peers</p> <p>People who live in agency-owned housing grouped with others with disabilities and go to segregated day programs or sheltered workshops specifically for people with disabilities.</p>	<p>Passive Contact</p> <p>People you may greet in passing, or who wait on you in stores, or who you see on a regular basis. You recognize their face and not even know their name. We all have many of these people in our lives.</p>	<p>Incidental Interaction</p> <p>People who you know and see in certain places and usually only in those places. It's the people you exercise at the gym with or see in church, or at volunteer jobs. You know their names, you see them regularly, but only if you happen to show up at the same place at the same time.</p>	<p>Cooperative Interaction</p> <p>This level of interaction describes our friends. These are freely given relationships and include people with whom you "make plans". You usually share more than one interest with them and you are familiar with personal details of their lives including where they live, their families, and their work /hobbies.</p>	<p>Extended Relationships</p> <p>People who love you and whom you love. It also may include your very close friends.</p>

APPENDIX 10

DISCOVERY & CAREER PLANNING RESOURCES

APPENDIX 10A: DISCOVERY & CAREER PLANNING PATHWAY

Operational Guidelines: *Any newly approved DCP providers during this waiver renewal period must be in full compliance with the CMS HCBS Settings Final Rule and be able to demonstrate the provision of services in fully integrated community settings. For settings that were operating prior to July 1, 2016, the setting must be in compliance or working toward compliance as part of the **My Choice My Way** state transition plan.*

All waiver employment services are designed to result in competitive integrated employment; therefore, these services must not include employment under a 14(c) sub-minimum wage certificate program.

Step 1 – Initial Meeting: ISP meeting with CM to write a Discovery and Career Planning goals.

Provide Social Security Information: Provide the Benefits Planning Query information to the job seeker and support if applicable, and encourage them to contact Social Security and request their BPQY as soon as possible.

https://www.ssa.gov/disabilityresearch/documents/BPQY_Handbook_Version%205.2_7.19.2012.pdf

Select a Provider and make an Appointment: Provide the job seeker with a list of Benefits Counseling Providers and ask who they would like to complete their Benefits and Work Incentives Counseling Session with.

Provide an outline of Discovery Process and Career Planning: Explain Discovery and Career Planning and how it will be delivered by your agency. (Include any additional Agency Specific information at this time.)

Schedule Next Steps: Schedule initial home and neighborhood visit.

Step 2 – Begin Documentation: Complete identification information on the **Profile I Interview/Intake General Information form** before home visit.

Step 3 - Confirm Correct Information: During the home visit confirm that the information on the **Profile I Interview/Intake General Information form** is accurate.

Home Visit: The goal of the home visit is to learn as much about the job seeker as possible in the place he/she is most comfortable. Spending time with the job seeker is the best way to get the information you need to assist the job seeker with creating a career plan that encompasses a pathway to successful employment.

Home Interview: In addition to observing the job seeker in his/her home, begin interviewing family members and natural supports to complete Profile I and begin working on Profile II

Who: Ask the job seeker and supports to Identify three to five people who know the job seeker well that would agree to being interviewed. (Coaches, past teachers, neighbors, club members)

Note: This meeting is not to judge how someone lives, but to discover clues about the strengths and preferences of the job seeker. This meeting may last up to 2 hours.

Step 4 - *Get to know the job seeker:* to create a complete picture of the job seeker, interview people who know the job seeker well to help gather information on the following categories.

Background, Routines, Home life, Education, Employment history, Daily skills/chores, Transportation, Leisure activities at home and community, Acquired skills, Social Collateral Hobbies, Barriers, Self-Assessment

Step 5 - *Neighborhood Observation:* Complete a neighborhood observation documenting local businesses and resources.

Step 6 - *Mobility Training:* Begin Mobility Training to use a fixed route and/or paratransit public transportation as independently as possible. (Incorporate personal safety using transportation)

Step 7 - *Financial Information:* Review the results of the job seeker's benefits counseling report and have him/her identify how many hours per week they would like to work and how much money per hour they would like to earn.

Step 8 - *Community Observation:* Observe the job seeker in community activities and identify community members he/she interacts with. For example, Special Olympics, Religious Activities, or volunteering.

Step 9 - *Identify Conditions for Success:* Based on the job seekers **interest**, identify a few unfamiliar activity which they haven't tried before or visit places they haven't gone before and participate in this activity with them. Observe the job seeker to obtain more information about support needs, reactions, attention to natural cues etc.

Step 10 – *Task Analysis:* Identify and complete assessments that will define the job seekers skill level in the interests that this process has identified. For example, if the previous interviews and observations identify that the job seeker is interested in clerical work, assist him/her by conducting assessments in that area. Can he/she type, answer multi-line phone system, use computer programs, file information correctly, do they pay attention to detail? *Document all assessment outcomes in Profile III*

Step 11 – *Home Visit:* Return to the job seeker's home for additional information, unstructured conversations, observations and further interviews if needed.

Step 12 – *Complete Profile III:* Share the completed Profile II and III with the job seeker and family and ask for any corrections or clarifications.

Step 13 – *Vocational Themes:* After reviewing the three profiles from the discovery and career planning process identify three emerging themes that meld the tasks, interests, talents and skills of the individual. (These are not job descriptions or business ideas.)

For example: 1) Music 2) Sports 3) Crafts

Step 14 – *Discovery Community/Family Meeting*

Ask the job seeker to invite family members, neighbors and friends that know him/her well to their meeting at the venue of their choice.

Explain to the attendees what has been “Discovered” while the job seeker has been going through this process. Be sure to include, “Activities that have been completed (where you went and what you learned, Tasks preferred, Interests, Skills, Personal Attributes and desired Conditions and Work Culture.)

Ask members of the audience to help fill in the boxes with information they know from their personal experience knowing the job seeker. Keep the poster up to refer back to from time to time.

Step 15 – *Vocational Theme Application:* While at the meeting ask the members to help identify twenty (20) places for each theme where people with similar themes work in their desired commute area.

Example:

Theme 1: Music

1. Easy Music Center
2. The Republik
3. The Blaisdell Center

Theme 2: Sports

1. Bike Factory Sports Shop
2. Hustle Basketball Club
3. Lids Retail Store

Theme 3: Crafts

1. Ben Franklin Crafts
2. Clay Café Hawaii
3. Kidz Art Hawaii

For example, someone who has a vocational theme of Sports will have a mixture of the following: local sporting goods stores, sports education facilities, bowling alley, sports performance locations, local gym, place where sports equipment is manufactured etc. *NOTE: It is best if the list doesn't contain the same kind of businesses, for example 20 retail shops that sell sportswear.*

Step 16 – *Community Connections*

Document the names of the attendees, their contact information and where they work. This is the beginning of a network that may be beneficial throughout this process.

APPENDIX 10B: BENEFIT COUNSELING PROFILE

Benefit Counseling Profile

Benefits Counselor:

Date:

Time:

BENEFICIARY DEMOGRAPHIC AND CONTACT INFORMATION				
Last Name:	First Name:	MI:		
Mailing Address:				
City:	State:	Zip Code:		
Phone Number(s) :		Email Address:		
Representative Payee: <input type="checkbox"/> Yes <input type="checkbox"/> No		DOB: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Representative Payee Name:		Representative Payee Phone:		
Representative Payee Mailing Address:				
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er)				
Highest Level of Education Attained: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Less than H.S. <input type="checkbox"/> HS graduate / GED <input type="checkbox"/> Special Diploma <input type="checkbox"/> Some college <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Certification program (describe) <input type="checkbox"/> Post graduate degree (describe) <input type="checkbox"/> Current student (describe) <input type="checkbox"/> Other (describe) </td> </tr> </table>			<input type="checkbox"/> Less than H.S. <input type="checkbox"/> HS graduate / GED <input type="checkbox"/> Special Diploma <input type="checkbox"/> Some college <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree	<input type="checkbox"/> Certification program (describe) <input type="checkbox"/> Post graduate degree (describe) <input type="checkbox"/> Current student (describe) <input type="checkbox"/> Other (describe)
<input type="checkbox"/> Less than H.S. <input type="checkbox"/> HS graduate / GED <input type="checkbox"/> Special Diploma <input type="checkbox"/> Some college <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree	<input type="checkbox"/> Certification program (describe) <input type="checkbox"/> Post graduate degree (describe) <input type="checkbox"/> Current student (describe) <input type="checkbox"/> Other (describe)			
Do you have any goals to further your education? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Primary Disability / Disability of Record:				
Language / Accommodation Needs:				
Open with State VR? <input type="checkbox"/> Yes <input type="checkbox"/> No				

© University of Hawaii

1

Counselor Name:		
Phone Number:		
Ticket Status:		
CURRENT EMPLOYMENT STATUS		
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If currently working, describe:	start date job title employer	hours per week pay rate pay dates
If not working, describe your current employment goal:		
How many hours per week would you like to work?		
What would you like your hourly wage to be?		
WORK HISTORY SINCE ENTITLEMENT		
Employer:	Job Title:	
Start Date:	End Date:	
Pay Rate:	Hours/week:	
Employer:	Job Title:	
Start Date:	End Date:	
Pay Rate:	Hours/week:	
Has work been reported to Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, when and how?		

APPENDIX 11

RESPONSIBILITIES

APPENDIX 11A: STATE MEDICAID AGENCY RESPONSIBILITIES

1. Submit the Medicaid I/DD Waiver applications and amendments to the Centers for Medicare and Medicaid Services (CMS); serve as the liaison between the DOH-DDD and CMS.
2. Certify initial intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care for applicants applying for the Medicaid I/DD Waiver prior to their admission.
3. Verify or determine Medicaid eligibility of applicants applying for services from the Medicaid I/DD Waiver prior to admission.
4. Maintain a participant and fiscal information system capturing waiver service expenditures and related participant data for the Medicaid I/DD Waiver according to federal requirements.
5. Submit an annual 372 report to CMS; monitor the number of participants served by the Medicaid I/DD Waiver as well as the average per capita costs and total cost-neutrality expenditure ceilings approved by CMS.
6. Oversee DOH-DDD's quality assurance program including the compliance reviews of all Medicaid I/DD Waiver providers. Report to CMS the summary of results on a regular basis.
7. Cooperate with CMS during reviews of the Medicaid I/DD Waiver; compile fiscal records and other Medicaid I/DD Waiver data and provide these records to CMS upon request.
8. Support DOH-DDD billing efforts by:
 - a. Processing and maintaining Medicaid I/DD Waiver provider agreements with each provider deemed qualified by DOH-DDD to serve participants in the Medicaid I/DD Waiver;
 - b. Maintaining the DHS Hawaii Prepaid Medicaid Management Information System (HPMMIS) information on providers, authorized services, and rates, and providing information to DOH-DDD on a timely basis.
9. Conduct fair hearings to ensure due process to Medicaid I/DD Waiver participants and providers.
10. Develop and oversee the state transition plan for the Home and Community Based Services Community Integration final rule. Hawaii's state transition plan is titled My Choice My Way.

APPENDIX 11B: STATE OPERATING AGENCY RESPONSIBILITIES

1. Certify annually the ICF/IID level of care for Medicaid I/DD Waiver participants.
2. Provide targeted case management services to Medicaid I/DD Waiver participants, including assessment, ISP development, needs identification, service authorization, ongoing monitoring and service coordination.
3. Promote freedom of choice for Medicaid I/DD Waiver participants by informing them of feasible alternatives for choice of providers and waiver services, as well as the choice of institutional versus Medicaid I/DD Waiver services.
4. Provide the State match funds from general fund budget appropriations for the Medicaid I/DD Waiver as is available within the DOH-DDD budget in accordance with Chapter 333F, Hawaii Revised Statutes (HRS).
5. Serve as the lead in developing and drafting of the Medicaid I/DD Waiver application renewal and amendments, including service definitions, service standards, program's P&P, guidelines, and criteria for rate setting; collaborate with DHS-MQD and stakeholder groups (i.e., persons with developmental and intellectual disabilities, self-advocates, families, providers and other interested individuals or groups).
6. Determine eligibility for applicants seeking services under the Medicaid I/DD Waiver that is consistent with Chapter 333F, HRS.
7. Provide consultation to DHS-MQD on services, programs, and best practices for services and supports for persons with I/DD and provide consultation to DHS-MQD on related costs as needed.
8. Provide orientation to prospective providers of Medicaid I/DD Waiver services, review new provider applications, proposals from approved providers to expand its service array, and recommend providers to DHS-MQD for authorization to provide services under a Medicaid Provider Agreement.
9. Provide technical assistance to Medicaid I/DD Waiver providers to ensure these providers render services in accordance with the Medicaid Waiver Standards Manual (as provided in Section 3: Service-Specific Performance Standards) as well as best practices that are recognized at the federal and state levels for HCBS and community integration.
10. Communicate and coordinate with DHS-MQD, QUEST Integration health plans, and others to ensure participants have access to needed services and if necessary, to transition seamlessly from one service system to another.
11. Cooperate and support activities to recover any overpayments or inappropriate payments from Medicaid I/DD Waiver providers:
 - a. Cooperate and assist the DHS-MQD Fraud Unit by providing requested information;
 - b. Monitor Medicaid I/DD Waiver providers for potential fraud or abuse and report any suspected fraudulent activity to DHS-MQD and the Department of Attorney

General, Medicaid Fraud Control Unit within thirty (30) calendar days of discovery.

12. Review all complaints and Adverse Event Reports (AER) and maintain a database of all reports; respond to complaints and reports as needed; refer problems that require review and/or possible action to the Department of Attorney General.
13. Conduct quality assurance reviews of Medicaid I/DD Waiver participants and providers to ensure compliance with the CMS performance measures; submit reports to DHS-MQD as scheduled.
14. Cooperate with DHS-MQD in the performance of investigations, audits, quality assurance reviews of providers and CMS requests.
15. Collaborate with DHS-MQD, the My Choice My Way Advisory Group, providers and stakeholders to achieve and maintain compliance with the Home and Community Based Services Community Integration final rule. This includes completion of validation of all Medicaid I/DD Waiver settings that are identified by DHS-MQD as needing remediation to come into compliance; providing training and technical assistance to providers to develop their corrective action plans and remediation milestones; and monitoring provider progress toward achieving and maintaining compliance.

APPENDIX 11C: WAIVER PROVIDER RESPONSIBILITIES

1. Adhere to all Provider Agreement and attachments, Medicaid I/DD Waiver Standards, applicable federal, state and local laws, rules, and regulations.
2. Deliver services in accordance with the Medicaid I/DD Waiver Standards.
3. Complete Corrective Action Plans or other remediation requirements within the specified timeframes, including ***My Choice My Way*** state transition plan requirements.
4. Promote freedom of choice of providers by Medicaid I/DD Waiver participants
5. Assist with transition if participant chooses a different provider upon request of the Case Manager, with releases of information.
6. Perform training and other activities that develop a highly skilled workforce.
7. Stay current on national best practices for services and supports for persons with I/DD.
8. Maintain financial and service delivery records in accordance with Waiver Standards and state and federal laws and regulations.
9. Cooperate with activities to recover any overpayments or inappropriate payments as determined by DOH-DDD or DHS-MQD
10. Respond to inquiries by DOH-DDD or DHS-MQD within two (2) business days.
11. Cooperate with DOH-DDD or DHS-MQD for investigations, audits, and quality assurance reviews, including providing all documentation or records requested.

APPENDIX 12
CASE MANAGEMENT BRANCH
(CMB) FORMS

APPENDIX 12A: INDIVIDUALIZED SERVICE PLAN (ISP)

STATE OF HAWAII
Department of Health
Developmental Disabilities Division

_____'s Individualized Service Plan

MY CIRCLE OF SUPPORT

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

OTHER AGENCIES THAT SUPPORT ME:

- | | |
|--|---|
| <input type="checkbox"/> Division of Vocational Rehabilitation | <input type="checkbox"/> Child and Adolescent Mental Health |
| <input type="checkbox"/> Department of Education | <input type="checkbox"/> Adult Mental Health Division |
| <input type="checkbox"/> Other: _____ | |

- | | |
|--|--|
| <input type="checkbox"/> I chose the people in my meeting. | <input type="checkbox"/> I ran my meeting. |
| <input type="checkbox"/> I helped plan my meeting. | <input type="checkbox"/> I picked _____ to help me run my meeting. |

Case Manager: _____ Case Management Unit: _____

Case Manager's Address: _____

Case Manager's Telephone #: _____

CMB 06/16

STATE OF HAWAII
Department of Health
Developmental Disabilities Division

THIS IS WHO I AM

(Great things about me; Strengths; Positive words that describe me)



CMB 06/16

HOW I COMMUNICATE

- *When I'm sad, (e.g., I cry; I am quiet; etc.), I need you to ... (e.g. leave me alone).*
[REDACTED]
- *When I'm happy ...*
[REDACTED]
- *When I'm angry ..., I need you to ...*
[REDACTED]
- *When I'm sick/not feeling well ..., I need you to ... (e.g., take me to the doctor)*
[REDACTED]
- *The language I speak is ...*
[REDACTED]
- *I best communicate to others using . . . (e.g., my voice and words, sign language, my communication device, gestures)*
[REDACTED]
- *Other:*
[REDACTED]

WHAT'S IMPORTANT AND MEANINGFUL TO ME

(Control; Dignity; Respect; Choice; Relationships; Contributing to the Community; Responsibilities;
Dreams)

Put an asterisk (*) next to the areas to be addressed as priority goals.

- *WHERE I WANT TO LIVE –*
[REDACTED]
- *MY HEALTH AND WELL-BEING (concerns or goals I have) –*
[REDACTED]
- *MY SAFETY (what I need to feel safe and secure at home, at work, at school, in the community) –*
[REDACTED]
- *I WANT TO LEARN NEW THINGS/TRY NEW THINGS –*
[REDACTED]
- *I WANT TO WORK AND MAKE MONEY –*
[REDACTED]

WHAT'S IMPORTANT AND MEANINGFUL TO ME

(Control; Dignity; Respect; Choice; Relationships; Contributing to the Community; Responsibilities;
Dreams)

Put an asterisk (*) next to the areas to be addressed as priority goals.

- **MY RELATIONSHIPS WITH FAMILY AND FRIENDS –**
Intimacy and Personal Choice - (e.g., boyfriend/girlfriend, relationships, personal space)

■

- **LEISURE AND RECREATIONAL ACTIVITIES –**
I enjoy doing activities on my own like . . .

■

I enjoy doing activities with others like . . .

■

I enjoy doing activities in the community like . . .

■

- **THINGS I NEVER WANT IN MY LIFE ARE –** (e.g. to be in noisy places, to be alone)

■

- **OTHER IMPORTANT THINGS IN MY LIFE** (e.g. cultural, spiritual, religious traditions/celebrations)

■

STATE OF HAWAII
Department of Health
Developmental Disabilities Division

MY GOALS

**BASED ON "WHAT'S IMPORTANT AND MEANINGFUL TO ME", THESE ARE MY MOST
IMPORTANT GOALS FOR THIS YEAR:
Put an "I" next to the goals identified by the individual.**



CMB 06/16

INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 1 of 2)

Services/Support	Frequency and Duration	Start Date
Name:	Address:	Phone:
Rep: Print Name _____	Rep: Signature _____	Fax: _____
		Status
GOAL #1 <input type="checkbox"/> Self <input type="checkbox"/> Circle		
Outcomes:		
GOAL #2 <input type="checkbox"/> Self <input type="checkbox"/> Circle		
Outcomes:		
GOAL #3 <input type="checkbox"/> Self <input type="checkbox"/> Circle		
Outcomes:		

Signature of Individual, Guardian or Personal Rep.

Date

Signature of Case Manager

Date _____

CMB 06/16

INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 2 of 2)

		Status
GOAL #4		
<input type="checkbox"/> Self	<input type="checkbox"/>	
<input type="checkbox"/> Circle	<input type="checkbox"/>	
Outcomes:	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
RISK AND SAFETY (Potential risks and safety concerns to be addressed when supporting me):		
POTENTIAL RISK		SUPPORTS TO MINIMIZE RISK
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/> Functional Behavior Assessment (FBA) <input type="checkbox"/> Positive Behavior Support Plan <input type="checkbox"/> None		
Comments: <input type="checkbox"/>		

CMB 06/16

APPENDIX 12B: MY INFORMATION/EMERGENCY AND CRISIS PLANNING

State of Hawaii
Department of Health

Developmental Disabilities Division
Case Management Branch

MY INFORMATION

Guardianship: ☐ Family/Relative ☐ Office of the Public Guardian ☐ Department of Human Services
☐ None ☐ Other (specify) _____

Name	Address	City	State	Zip	Telephone No.(s)

☐ Guardianship Document on file

Conservator (Financial): ☐ Family/Relative ☐ Estate and Probate ☐ Office of the Public Guardian
☐ Department of Human Services ☐ Other (specify) _____
☐ Representative Payee ☐ None

Name	Address	City	State	Zip	Telephone No.(s)

Legal Issues: (e.g. guardianship pending, on probation, court involvement, power of attorney)

Medicaid Eligibility: As a reminder, failure to renew your Medicaid eligibility may result in the TERMINATION of your medical benefits and your DD/ID waiver services.

Eligibility Worker	Business Address	Medicaid Unit	Medicaid Eligibility Month (if known)	Telephone No.

Person Responsible to complete Annual Medicaid Application: _____

☐ Medicaid Ineligible

Date: _____

Name

Relationship

Health Insurance: (check all that apply):

☐ Medicaid Policy No: _____ ☐ QI Plan: _____

☐ Cost Share: _____

☐ Medicare: Part: A ☐ B ☐ D ☐ Prescription Drug Plan Name: _____

☐ Dental: Name: _____ Policy No. _____

☐ Other: Name: _____ Policy No. _____

☐ Other: Name: _____ Policy No. _____

NAME:
ANNUAL DATE:

1

BIRTHDATE:

CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED

CP 7-1 08/16

MY INFORMATION

WHERE I LIVE

- ☐ On my own ☐ Adult Foster Home (AFH)
☐ Family/Relatives Home ☐ DD Domiciliary Home (Dom)
☐ Adult Residential Care Home (ARCH) ☐ Other: specify: _____

My Parent/Caregiver's Name: _____

My Address and Telephone No.: _____

MY HEALTH

Diagnosis/Medical Condition

- | | |
|--|----------|
| 1. _____
<small>(ICD-10 Code and Diagnosis)</small> | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Allergies: ☐ Known: (Medications, Food, Environment) ☐ None

Specify: 1. _____ 3. _____ Height: _____
 2. _____ 4. _____ Weight: _____

Physical Limitations: _____ ☐ G-Tube ☐ J-Tube ☐ Other (specify): _____

Diet Type: _____

Diet Texture: ☐ Regular ☐ Chopped ☐ Ground ☐ Pureed ☐ Liquid Consistency: _____

Type of Examination/Procedure	Date Completed	Date Next Exam Due	Comments
Physical Exam			
Dental Exam			
Eye Exam			
Hearing Exam			
PPD or Chest x-ray			
Prostate Exam (Men)			
PAP Smear (Women)			
Mammogram (Women)			

NAME:
ANNUAL DATE:

2

BIRTHDATE:

CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED

CP 7-1 08/16

MY HEALTH SUPPORTS

MEDICATIONS:

Medications Current as of: _____

No.	Medication	Dosage	Frequency	Purpose	Prescribing M.D.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					

NAME:
ANNUAL DATE:

3

BIRTHDATE:

CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED

CP 7-1 08/16

MY HEALTH SUPPORTS

PRIMARY M.D. _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Dentist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

Other M.D./Specialist _____ Specialty: _____ Phone number: _____
Address: _____ Last Visit: _____ Next Visit: _____
Medical Concerns/Precautions: _____

NAME:
ANNUAL DATE:

4

BIRTHDATE:

CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED

CP 7-1 06/16

I use the following ADAPTIVE EQUIPMENT/ASSISTIVE TECHNOLOGY			
Equipment/Technology	Purpose	Vendor	If known, last maintenance check

I use the following MEDICAL SUPPLIES		
Item	Purpose	Vendor

BEHAVIORAL SUPPORTS		
Attachments:	<input type="checkbox"/> Functional Behavior Assessment <input type="checkbox"/> Positive Behavior Support Plan	Date Completed: _____ Date Completed: _____
Identified Restraints: Check all that apply:		Behavior Support Review Committee (BSRC):
<input type="checkbox"/> Chemical	Date Implemented: _____	Referral Date: _____
<input type="checkbox"/> Physical	Date Implemented: _____	Review Date: _____
<input type="checkbox"/> Mechanical	Date Implemented: _____	Review Date: _____
Comments: 		

NAME:
ANNUAL DATE:

5

BIRTHDATE:

CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED

CP 7-1 08/16

A. POLICE ASSISTANCE OR MEDICAL EMERGENCY – CALL 911

Hospital Preference: _____

B. CRISIS HOTLINE NUMBER: 590-1769 (Oahu Only)
For Behavioral Emergencies 1-866-599-9211 (Neighbor Island Only)

C. Poison Center 1-800-222-1222

D. Other: _____

Identification of a natural support who is willing to provide back-up supports for individuals living on their own or with their family.

Name	Relationship	Address	City	State	Zip	Telephone No.(s)

Items for Disaster Preparedness

Personal Emergency Kit:

☐ I have a kit☐ I need a kit

Medical Identification Bracelet:

☐ I have a bracelet☐ I need a bracelet☐ Not applicable

A copy of the Guidelines for Personal Disaster Preparation for Individuals with Special Needs:

☐ I have a copy☐ I need a copy

A "buddy" to help me if there is a hurricane or tsunami:

☐ I have a "buddy"☐ I need a "buddy"

Name of my "buddy":

Address and Telephone No. of my "buddy":

Who will help me get the items I need:

When this will be done by:

If evacuation is necessary, I will evacuate to (name at least two shelters in your area):

Comments:

NAME:
ANNUAL DATE:

18

BIRTHDATE:

**CONFIDENTIAL – DO NOT DUPLICATE
CONSENT IS REQUIRED**

CP 7-1 06/16

APPENDIX 12C: PHYSICIAN'S RECOMMENDATION FOR ICF-I/DD LEVEL OF CARE

STATE OF HAWAII
Department of Health
Developmental Disabilities Division

PHYSICIAN'S RECOMMENDATION FOR ICF-DD/ID LEVEL OF CARE

I. Identifying Information

Name of Individual: _____
First Name
Middle Initial
Last Name

Birth date: _____

II. Significant Diagnoses/Health Conditions and Medications

DIAGNOSES/CONDITIONS	MEDICATIONS (Type/Dosage)
1.	
2.	
3.	
4.	
5.	

III. Medical/Health Procedures (Circle if identified as needed by the individual):

- | | |
|---|-------------------------------------|
| 1. Intravenous or Intramuscular therapy | 2. Urinary catheter with irrigation |
| 3. Catheter feeding (N/G or gastrostomy) | 4. Dressings |
| 5. Nasopharyngeal and tracheostomy aspiration | 6. Decubitus or skin disorders |
| 7. Therapy (circle): PT, OT, Speech | 8. Medical gases |
| 9. Therapeutic diet (specify): | |
| 10 Other (specify): | |

IV. Support/Habilitation Needs

Areas of Support/Training Needs	Yes	No
1. Behavior: e.g., sexually inappropriate; self abusive; aggressive; health/safety risk		
2. Communication: e.g., unable to/has difficulty re: communicating needs/wants		
3. Transfers: e.g., needs help with transfers from bed, chair or toilet		
4. Mobility: e.g., needs help to move about in community or to ambulate		
5. Feeding: e.g., unable to or needs assistance with feeding and/or meal preparation		
6. Bowel or Bladder Function: e.g., has enuresis or encopresis		
7. Personal hygiene: e.g., unable to or needs assistance in bathing or grooming		
8. Cognitive/Social Skills: e.g., needs assistance to make choices/manage money/household chores/leisure activity, to access community resources, with social relationships		

V. Recommendation for ICF-DD/ID Level of Care: ☐ Yes ☐ No Date: _____

Print/Type Name of Physician

Signature of Physician

DOH-DDD/CMB
(Rev. 04/14)

APPENDIX 12D: CONSENT FOR SERVICES

STATE OF HAWAII
Department of Health
Developmental Disabilities Division



CONSENT FOR SERVICES

I/We have reviewed the attached Individualized Service Plan (ISP) for _____
dated _____.

1. This plan was developed with me and/my guardian and other individuals of my choosing. It includes the goals that are important from my health and safety. _____
Initials
2. The choice of services and the providers of these service(s) were reviewed with me. The choice to self-direct (for Personal Assistance Habilitation (PAB), respite, and chore) was also offered to me. I, have, of my own free will, chosen to receive this service from the provider noted in the Action Plan of the ISP). _____
Initials

PLEASE MARK THE APPROPRIATE BOX

- ☐ I/We agree or consent to the ISP.
- ☐ I/We would like to discuss the ISP. Please contact me at (Phone No.): _____

If you were not present at the ISP meeting and would like to discuss any of the details in the ISP, you can contact your case manager at _____. You can also contact your case manager at any time when you feel your plan needs to be updated or changed.

Your Rights:

If you do not approve or do not sign the proposed ISP and the current ISP has expired, your services may be terminated, per Hawaii Administrative Rules § 11-88.1-10. **It is important that you sign and return this page to your case manager within 14 calendar days of receiving this form.**

If you signed the Consent for Services but disagree with the services and/or supports in your ISP, you can request for an informal discussion at any time with staff from the Developmental Disabilities Division. Please contact _____, case management unit supervisor, at _____. You can also contact the Consumer Complaints Resolution Unit at 453-6669.

For Medicaid waiver services, prior to any suspension, reduction, or termination of services, you will be notified in writing. If you disagree with the proposed action, the "Notice of Action" will explain your appeal options. These include an informal review with the Developmental Disabilities Division, an administrative hearing with the Department of Health, and/or an administrative hearing with the Department of Human Services.

Participant's Signature _____	Print Name _____	Date _____
Signature of: _____	Print Name _____	Date _____
_____ Parent		
_____ Legal Guardian		
_____ Personal Representative		

CMB 66/16

APPENDIX 12E: SERVICES & PROVIDER AUTHORIZATION FORM – I/DD WAIVER

STATE OF HAWAII
Department of Health

Developmental Disabilities Division
Case Management Branch

SERVICES & PROVIDER AUTHORIZATION FORM - I/DD WAIVER DOH/Developmental Disabilities Division/Case Management Branch

PARTICIPANT NAME		MEDICAID ID NUMBER		DATE OF BIRTH	
LAST	FIRST	MI		M	M / D / Y Y Y
ACTION REQUESTED: (CHECK ALL THAT APPLY) <input type="checkbox"/> ADD SERVICE <input type="checkbox"/> CHANGE SERVICE <input type="checkbox"/> ADD PROVIDER <input type="checkbox"/> CHANGE PROVIDER					
CASE MANAGER			CASE MANAGEMENT UNIT/PHONE NUMBER		
			/		
PROVIDER INFORMATION					
Provider Agency: _____ agrees to provide the requested service(s) to the above-named participant.					
Services <input type="checkbox"/> Adult Day Health (ADH) <input type="checkbox"/> Additional Residential Supports <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Benefits Counseling <input type="checkbox"/> Chore <input type="checkbox"/> Community Learning Services (CLS) <input type="checkbox"/> Discovery and Career Planning			<input type="checkbox"/> EAA – Construction <input type="checkbox"/> EAA – Permits <input type="checkbox"/> Individual Employment Supports – Job Development <input type="checkbox"/> Individual Employment Supports – Job Coaching <input type="checkbox"/> Non-Medical Transportation <input type="checkbox"/> Personal Assistance Habilitation (PAB) <input type="checkbox"/> Personal Emergency Response System		
SIGNATURE OF PROVIDER AGENCY REPRESENTATIVE _____ PRINT/TYPE NAME _____			DATE _____ TITLE _____		
PARTICIPANT AUTHORIZATION The participant in the Home and Community Based I/DD Waiver has requested the above-named authorized provider to provide the above-named service(s). The choice of waiver service(s) and provider(s) of these service(s) has been reviewed.					
PARTICIPANT SIGNATURE _____ DATE _____			RESPONSIBLE PARTY SIGNATURE/RELATIONSHIP TO PARTICIPANT _____ DATE _____		
CASE MANAGER SIGNATURE		DATE	UNIT SUPERVISOR SIGNATURE		DATE
BUDGET WORKSHEET SUBMITTED		DATE:	SERVICE		START DATE
COPY TO PARTICIPANT/GUARDIAN		DATE:			
COPY TO AGENCY PROVIDER		DATE:			

Waiver : Services 18-1 07/2017

APPENDIX 12F: ICF-I/DD LEVEL OF CARE RE-EVALUATION

STATE OF HAWAII
Department of Health

DEVELOPMENTAL DISABILITIES DIVISION
Case Management Branch

STATE OF HAWAII ICF-DD/ID Level of Care Re-Evaluation

1. Participant Name (Last, First, M.I.)		2. Birthdate	3. Medicaid ID #
4. DD/ID Waiver Admission Date	5. Initial ICF-DD/ID Level of Care (LOC) Date:	6. Case Manager Name:	
7. Case Management Unit (CMU) No.	8. CMU Phone #:	9. CMU Fax #:	

CASE MANAGER RECOMMENDATION			
The following information was used to review and re-evaluate the participant named above. Check all that apply. These report(s) and/or evaluation(s) support the recommended level of care.			
Used	Attached	Item	Date of Rpt
<input type="checkbox"/>	<input type="checkbox"/>	Physician's Evaluation (required)	
<input type="checkbox"/>	<input type="checkbox"/>	ICAP (required): Service Score _____ Maladaptive Score _____	
<input type="checkbox"/>	<input type="checkbox"/>	Psychological Evaluation	
<input type="checkbox"/>	<input type="checkbox"/>	ABAS	
<input type="checkbox"/>	<input type="checkbox"/>	Participant interview	
<input type="checkbox"/>	<input type="checkbox"/>	Provider reports	
<input type="checkbox"/>	<input type="checkbox"/>	Quarterly health monitoring assessments	
<input type="checkbox"/>	<input type="checkbox"/>	Referral to Clinical Interdisciplinary Team (Recommendation must be attached)	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	

☐ Meets ICF-DD/ID level of care
☐ Does not meet ICF-DD/ID level of care

Signature: _____

Case Manager
Date

Qualified Intellectual Disabilities Professional Determination	
<input type="checkbox"/> Meets ICF-DD/ID level of care <input type="checkbox"/> Does not meet ICF-DD/ID level of care (Send to DHS/MQD for review with attachments)	
Signature: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10%;"> Unit Supervisor Date </div>	

To be completed only if determination is Does Not Meet ICF-DD/ID LOC	
I have reviewed and concur with the determination that the participant does not meet ICF-DD/ID level of care	
Signature: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10%;"> Section Supervisor Date </div>	
I agree/disagree with DDD's determination. Comments: _____	
Signature: _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10%;"> DHS Representative Date </div>	

APPENDIX 12G: NOTICE OF ACTION

DAVID Y. IGE
GOVERNOR OF HAWAII



VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES DIVISION
3627 Kilauea Avenue, Room 104
HONOLULU, HI 96816
February 1, 2017
Notice Date

Participant's Name _____

C/O (if applicable) _____

Address _____

City _____ State _____ Zip Code _____

Dear _____,
Participant Name

RE: Notice of Action

Effective February 15, 2017, the Developmental Disabilities Division (DDD) will DECREASE YOUR SERVICES because current services or level of services are not necessary based on an assessment by the DDD.

Your Personal Assistance Habilitation services will decrease from 21 hours per week to 14 hours per week.

Sincerely,

Case Manager Signature

Case Manager Name _____ Telephone No. _____ Unit No. _____

Unit Supervisor Signature

YOUR RIGHTS are listed on Page 2 of this Notice.

YOUR RIGHTS:

If you do not agree with the action taken in this notice, you may ask for an informal review of the action with staff from the Department of Health (DOH), Developmental Disabilities Division (DDD); an administrative hearing from the DOH; and if receiving Medicaid waiver services, an administrative hearing from the Department of Human Services (DHS). You may choose to exercise one or more of these options. Please follow the timelines and instructions below.

DEPARTMENT OF HEALTH:

1. **Informal Review:** An informal review with staff from the DDD, pursuant to Hawaii Administrative Rules (HAR) chapter 11-88.1. **Within 15 working days of the date of this Notice of Action**, you may ask for an informal review by sending a written request with this Notice of Action (NOA) and your contact information (telephone number and email address) to DDD, Attn: Informal Reviews, 2201 Waimano Home Road, Pearl City, HI 96782.

During the informal review, you will be given an opportunity to present information to members of the DDD staff to show that the proposed action is incorrect. You may choose to explain circumstances about your needs and your situation which you think the DDD staff may not be aware of and which might result in a different action. You will receive a written decision within 30 working days from the date of your request for an informal review.

2. **Administrative Hearing:** An administrative hearing with the DOH through a Hearings Officer conducted in accordance with Hawaii Revised Statutes (HRS) chapter 91 and HAR chapters 11-1 and 11-88.1.

At the administrative hearing, you may present relevant evidence and argument on the issues raised. You may also examine and cross-examine witnesses and present exhibits. After the administrative hearing is held, the action may be affirmed, modified, or reversed by the Hearings Officer.

If you are dissatisfied with the action from your informal review, you may file your request for an administrative hearing with the DOH within 15 working days of the date of the written informal review decision. Send your written request with this Notice of Action, the written decision from the informal review, and your contact information (telephone number and email address) to: Hearings Office, Department of Health, P.O. Box 3378, Honolulu, HI 96801.

If you did not request an informal review, you may file your request for an administrative hearing within 15 working days of the date of this Notice of Action. Send your written request with this Notice of Action and your contact information (telephone number and email address) to: Hearings Office, Department of Health, P. O. Box 3378, Honolulu, HI 96801.

DEPARTMENT OF HUMAN SERVICES:

3. **Administrative Hearing:** An administrative hearing with the DHS conducted in accordance with HRS chapter 91 and HAR chapter 17-1703.1. This option is only available to participants in the Medicaid waiver program.

Within 90 days of the date of this Notice of Action, you may file your written request for an administrative hearing with the DHS. Send your written request with this Notice of Action, the written decision from the DOH informal review and/or the DOH administrative hearing, if applicable, and your contact information (telephone number and email address) to: Department of Human Services, Administrative Appeals Office, P.O. Box 339, Honolulu, HI 96809.

You will be notified of the date, time and place of the review or hearing. If you request any or all of the appeal options above, your services will continue during the appeal process pursuant to HAR sections 11-88.1-19 and 11-88.1-20. Although the law requires your services to continue during an appeal, any aid paid for Medicaid waiver services pending a hearing decision shall be recoverable by the department if the proposed action is sustained. This is pursuant to Federal Medicaid law, 42 Code of Federal Regulations section 431.230 and HAR section 17-1703.1-17.

Representation:

At the informal review, you may speak for yourself or have a lawyer, friend, or other person speak for you. Be prepared to say why you are dissatisfied with the action and how the action adversely affects you. At the administrative hearing, you may be represented by counsel at your own expense. The local Legal Aid Office or the Hawaii Disability Rights Center may be able to assist and represent you.

DDD-Notice of Action
01/25/17

Page 2

APPENDIX 12H: NOTIFICATION TO TERMINATE SERVICE(S) – I/DD WAIVER

Developmental Disabilities Division
Case Management Branch

STATE OF HAWAII
Department of Health

NOTIFICATION TO TERMINATE SERVICE(S) - I/DD WAIVER DOH/Developmental Disabilities Division/Case Management Branch

PARTICIPANT NAME <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="display: flex; justify-content: space-between; font-size: 8px;"> LAST FIRST MI </div> </div> <div style="width: 10%; text-align: center;"> </div> <div style="width: 40%;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">MEDICAID ID NUMBER</div> </div> </div>	
ACTION REQUESTED: Terminate service(s) as indicated below.	
CASE MANAGER <div style="border-bottom: 1px solid black; width: 100%;"></div>	CASE MANAGEMENT UNIT/PHONE NUMBER <div style="border-bottom: 1px solid black; width: 100%;"></div>
PROVIDER INFORMATION <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> Services <input type="checkbox"/> Adult Day Health (ADH) <div style="border-bottom: 1px solid black; width: 50px;"></div> <input type="checkbox"/> Additional Residential Supports <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Benefits Counseling <input type="checkbox"/> Chore <input type="checkbox"/> Community Learning Services (CLS) <div style="border-bottom: 1px solid black; width: 50px;"></div> <input type="checkbox"/> Discovery and Career Planning </div> <div style="width: 35%;"> <input type="checkbox"/> EAA – Construction <input type="checkbox"/> EAA – Permits <input type="checkbox"/> Individual Employment Supports – Job Development <input type="checkbox"/> Individual Employment Supports – Job Coaching <input type="checkbox"/> Non-Medical Transportation <input type="checkbox"/> Personal Assistance Habilitation (PAB) <div style="border-bottom: 1px solid black; width: 50px;"></div> <input type="checkbox"/> Personal Emergency Response System </div> <div style="width: 30%;"> <input type="checkbox"/> Residential Habilitation (ResHab) <div style="border-bottom: 1px solid black; width: 50px;"></div> <input type="checkbox"/> Respite <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Specialized Equipment <input type="checkbox"/> Specialized Supplies <input type="checkbox"/> Training and Consultation <div style="border-bottom: 1px solid black; width: 50px;"></div> <input type="checkbox"/> Vehicular Modification <input type="checkbox"/> Other: <div style="border-bottom: 1px solid black; width: 50px;"></div> </div> </div>	
PARTICIPANT AUTHORIZATION <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">PROVIDER NAME</div>	
The participant in the Home and Community Based I/DD Waiver consents to terminate the indicated service(s) from the Provider named above.	
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">PARTICIPANT SIGNATURE</div>	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">DATE</div>
<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">RESPONSIBLE PARTY SIGNATURE/RELATIONSHIP TO PARTICIPANT</div>	<div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="text-align: right; font-size: 8px;">DATE</div>
CASE MANAGER SIGNATURE <div style="border-bottom: 1px solid black; width: 100%;"></div>	UNIT SUPERVISOR SIGNATURE <div style="border-bottom: 1px solid black; width: 100%;"></div>
COPY TO PARTICIPANT/GUARDIAN <div style="border-bottom: 1px solid black; width: 100%;"></div>	DATE: <div style="border-bottom: 1px solid black; width: 100%;"></div>
COPY TO AGENCY PROVIDER <div style="border-bottom: 1px solid black; width: 100%;"></div>	DATE: <div style="border-bottom: 1px solid black; width: 100%;"></div>
<div style="border-bottom: 1px solid black; width: 100%;"></div>	END DATE <div style="border-bottom: 1px solid black; width: 100%;"></div>

Waiver : Services 18-2 07/2017

APPENDIX 13

I/DD Waiver Services

Schedule of Rates

I/DD WAIVER SERVICES SCHEDULE OF RATES

Medicaid Waiver Services I/DD Waiver Services Schedule of Rates							
HPMMIS Provider Number:							
Name of Agency:							
Address:							
Geographical Service Area:							
Effective Date:		July 1, 2017					
Event Type	Place of Service	Procedure Code	Modifier	Type of Waiver Service	HPMMIS Procedure	Unit	Rate
HH	12	T1019	U6	Personal Assistance/Habilitation Level 1 (1:1)	Personal Care	15 Minute	\$6.54
HH	12	T1019	U6	BI Personal Assistance/Habilitation Level 1 (1:1)	Personal Care	15 Minute	\$6.54
HH	12	T1019	U7	Personal Assistance/Habilitation Level 1 (2:1)	Personal Care	15 Minute	\$13.08
HH	12	T1019	U7	BI Personal Assistance/Habilitation Level 1 (2:1)	Personal Care	15 Minute	\$13.08
HH	12	T1019	U8	Personal Assistance/Habilitation Level 1 (3:1)	Personal Care	15 Minute	\$19.62
HH	12	T1019	U8	BI Personal Assistance/Habilitation Level 1 (3:1)	Personal Care	15 Minute	\$19.62
HH	12	T1019	U9	Personal Assistance/Habilitation Level 1 (4:1)	Personal Care	15 Minute	\$26.16
HH	12	T1019	U9	BI Personal Assistance/Habilitation Level 1 (4:1)	Personal Care	15 Minute	\$26.16
HH	12	T1020		Personal Assistance/ Habilitation Level 1, Daily	Personal Care	Daily	\$460.42

HH	12	T1020		BI Personal Assistance/ Habilitation Level 1, Daily	Personal Care	Daily	\$460.42
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HH	12	T1019	UA	Personal Assistance/Habilitation Level 2 (1:1)	Personal Care	15 Minute	\$7.25
HH	12	T1019	UA	BI Personal Assistance/Habilitation Level 2 (1:1)	Personal Care	15 Minute	\$7.25
HH	12	T1019	UB	Personal Assistance/Habilitation Level 2 (2:1)	Personal Care	15 Minute	\$14.50
HH	12	T1019	UB	BI Personal Assistance/Habilitation Level 2 (2:1)	Personal Care	15 Minute	\$14.50
HH	12	T1019	UC	Personal Assistance/Habilitation Level 2 (3:1)	Personal Care	15 Minute	\$21.75
HH	12	T1019	UC	BI Personal Assistance/Habilitation Level 2 (3:1)	Personal Care	15 Minute	\$21.75
HH	12	T1019	UD	Personal Assistance/Habilitation Level 2 (4:1)	Personal Care	15 Minute	\$29.00
HH	12	T1019	UD	BI Personal Assistance/Habilitation Level 2 (4:1)	Personal Care	15 Minute	\$29.00
HH	12	T1019	U2	Personal Assistance/Habilitation Level 3 (1:1)	Personal Care	15 Minute	\$8.58
HH	12	T1019	U2	BI Personal Assistance/Habilitation Level 3 (1:1)	Personal Care	15 Minute	\$8.58
HH	12	T1019	U3	Personal Assistance/Habilitation Level 3 (2:1)	Personal Care	15 Minute	\$17.16

HH	12	T1019	U3	BI Personal Assistance/Habilitation Level 3 (2:1)	Personal Care	15 Minute	\$17.16
HH	12	T1019	U4	Personal Assistance/Habilitation Level 3 (3:1)	Personal Care	15 Minute	\$25.74

HH	12	T1019	U4	BI Personal Assistance/Habilitation Level 3 (3:1)	Personal Care	15 Minute	\$25.74
HH	12	T1019	U5	Personal Assistance/Habilitation Level 3 (4:1)	Personal Care	15 Minute	\$34.32
HH	12	T1019	U5	BI Personal Assistance/Habilitation Level 3 (4:1)	Personal Care	15 Minute	\$34.32
HH	12	S5125	HM	Personal Assistance/Habilitation, Registered Behavior Technician, 1:1	Personal Care	15 Minute	\$10.53
HH	12	99509	HM	BI Personal Assistance/Habilitation, Registered Behavior Technician, 1:1	Personal Care	15 Minute	\$11.95
HH	12	S5125	U9	Personal Assistance/Habilitation, Registered Behavior Technician, 2:1	Personal Care	15 Minute	\$16.86
HH	12	99509	U9	BI Personal Assistance/Habilitation, Registered Behavior Technician, 2:1	Personal Care	15 Minute	\$18.77
HH	12	S5125	UD	Personal Assistance/Habilitation, Registered Behavior Technician, 3:1	Personal Care	15 Minute	\$23.20
HH	12	99509	UD	BI Personal Assistance/Habilitation, Registered Behavior Technician, 3:1	Personal Care	15 Minute	\$25.59
OC	14, 33, 99	H0044	U1	Residential Habilitation, Tier 1, 3-bed	Habilitation, Residential, Waiver	Day	\$115.29
OC	14, 33, 99	T2033	U1	BI Residential Habilitation Tier 1, 3-bed	Habilitation, Residential, Waiver	Day	\$120.64

OC	14, 33, 99	H0044	U2	Residential Habilitation, Tier 1, 4-bed	Habilitation, Residential, Waiver	Day	\$99.29
OC	14, 33, 99	T2033	U2	BI Residential Habilitation, Tier 1, 4-bed	Habilitation, Residential, Waiver	Day	\$103.24
OC	14, 33, 99	H0044	U3	Residential Habilitation, Tier 1, 5-bed	Habilitation, Residential, Waiver	Day	\$89.70
OC	14, 33, 99	T2033	U3	BI Residential Habilitation, Tier 1, 5-bed	Habilitation, Residential, Waiver	Day	\$92.81

OC	14, 33, 99	H0044	U4	Residential Habilitation, Tier 2, 3-bed	Habilitation, Residential, Waiver	Day	\$159.04
OC	14, 33, 99	T2033	U4	BI Residential Habilitation, Tier 2, 3-bed	Habilitation, Residential, Waiver	Day	\$164.17
OC	14, 33, 99	H0044	U5	Residential Habilitation, Tier 2, 4-bed	Habilitation, Residential, Waiver	Day	\$140.32
OC	14, 33, 99	T2033	U5	BI Residential Habilitation, Tier 2, 4-bed	Habilitation, Residential, Waiver	Day	\$144.05
OC	14, 33, 99	H0044	U6	Residential Habilitation, Tier 2, 5-bed	Habilitation, Residential, Waiver	Day	\$129.09
OC	14, 33, 99	T2033	U6	BI Residential Habilitation, Tier 2, 5-bed	Habilitation, Residential, Waiver	Day	\$131.98
OC	14, 33, 99	H0044	U7	Residential Habilitation, Tier 3, 3-bed	Habilitation, Residential, Waiver	Day	\$180.93
OC	14, 33, 99	T2033	U7	BI Residential Habilitation, Tier 3, 3-bed	Habilitation, Residential, Waiver	Day	\$185.94
OC	14, 33, 99	H0044	U8	Residential Habilitation, Tier 3, 4-bed	Habilitation, Residential, Waiver	Day	\$156.73
OC	14, 33, 99	T2033	U8	BI Residential Habilitation, Tier 3, 4-bed	Habilitation, Residential, Waiver	Day	\$160.38
OC	14, 33, 99	H0044	U9	Residential Habilitation, Tier 3, 5-bed	Habilitation, Residential, Waiver	Day	\$142.21
OC	14, 33, 99	T2033	U9	BI Residential Habilitation, Tier 3, 5-bed	Habilitation, Residential, Waiver	Day	\$145.05
OC	14, 33, 99	H0044	UA	Residential Habilitation, Adult Therapeutic Living Program	Habilitation, Residential, Waiver	Day	\$499.23

OC	14, 33, 99	T2033	UA	BI Residential Habilitation, Adult Therapeutic Living Program	Habilitation, Residential, Waiver	Day	\$502.58
OC	14, 33, 99	T1004		Additional Residential Supports	Habilitation, Residential, Waiver	15 Minute	\$5.58
OC	14, 33, 99	99600		BI Additional Residential Supports	Habilitation, Residential, Waiver	15 Minute	\$5.76
AD	99	H2032	U1	Adult Day Health, Tier 1	Day Care Services, Adult, Tier 1	15 Minute	\$2.70
AD	99	S5100	U1	BI Adult Day Health, Tier 1	Day Care Services, Adult, Tier 1	15 Minute	\$3.06
AD	99	H2032	U2	Adult Day Health, Tier 2	Day Care Services, Adult, Tier 2	15 Minute	\$3.35

AD	99	S5100	U2	BI Adult Day Health, Tier 2	Day Care Services, Adult, Tier 2	15 Minute	\$3.78
AD	99	H2032	U3	Adult Day Health, Tier 3	Day Care Services, Adult, Tier 3	15 Minute	\$4.00
AD	99	S5100	U3	BI Adult Day Health, Tier 3	Day Care Services, Adult, Tier 3	15 Minute	\$4.46
AD	99	H2032	U4	Adult Day Health, 1:1	Day Care Services, Adult, 1:1	15 Minute	\$7.62
AD	99	S5100	U4	BI Adult Day Health, 1:1	Day Care Services, Adult, 1:1	15 Minute	\$8.38
AD	99	H2032	U5	Adult Day Health, Registered Behavior Technician, 1:1	Day Care Services, Adult, Per 15 Minutes	15 Minute	\$9.29
AD	99	S5100	U5	BI Adult Day Health, Registered Behavior Technician, 1:1	Day Care Services, Adult, Per 15 Minutes	15 Minute	\$10.18
HL	99	H2021	U1	Community Learning Service, Group, Tier 1	Habilitation, Day, Waiver	15 Minute	\$3.97
HL	99	T2021	U1	BI Community Learning Service, Group, Tier 1	Habilitation, Day, Waiver	15 Minute	\$4.56
HL	99	H2021	U2	Community Learning Service, Group, Tier 2	Habilitation, Day, Waiver	15 Minute	\$5.26
HL	99	T2021	U2	BI Community Learning Service, Group, Tier 2	Habilitation, Day, Waiver	15 Minute	\$5.94

HL	99	H2021	U3	Community Learning Service, Group, Tier 3	Habilitation, Day, Waiver	15 Minute	\$6.52
HL	99	T2021	U3	BI Community Learning Service, Group, Tier 3	Habilitation, Day, Waiver	15 Minute	\$7.31
HL	99	H2021	U4	Community Learning Service, Individual	Habilitation, Day, Waiver	15 Minute	\$7.91
HL	99	T2021	U4	BI Community Learning Service, Individual	Habilitation, Day, Waiver	15 Minute	\$9.50
HL	99	H2021	UN	Community Learning Service, 2:1	Habilitation, Day, Waiver	15 Minute	\$14.24
HL	99	T2021	UN	BI Community Learning Service, 2:1	Habilitation, Day, Waiver	15 Minute	\$16.32
HL	99	H2021	UP	Community Learning Service, 3:1	Habilitation, Day, Waiver	15 Minute	\$20.58
HL	99	T2021	UP	BI Community Learning Service, 3:1	Habilitation, Day, Waiver	15 Minute	\$23.13

HL	99	H2021	U6	Community Learning Service, Registered Behavior Technician, 1:1	Habilitation, Day, Waiver	15 Minute	\$11.06
HL	99	T2021	U6	BI Community Learning Service, Registered Behavior Technician, 1:1	Habilitation, Day, Waiver	15 Minute	\$12.86
HL	99	H2021	U7	Community Learning Service, Registered Behavior Technician, 2:1	Habilitation, Day, Waiver	15 Minute	\$17.39
HL	99	T2021	U7	BI Community Learning Service, Registered Behavior Technician, 2:1	Habilitation, Day, Waiver	15 Minute	\$19.67
HL	99	H2021	U8	Community Learning Service, Registered Behavior Technician, 3:1	Habilitation, Day, Waiver	15 Minute	\$23.73
HL	99	T2021	U8	BI Community Learning Service, Registered Behavior Technician, 3:1	Habilitation, Day, Waiver	15 Minute	\$26.49
CT	18, 99	S9445	U2	Discovery and Career Planning, Benefits Counseling	Employment	15 Minute	\$13.17
CT	18, 99	S9445	U1	BI Discovery and Career Planning, Benefits Counseling	Employment	15 Minute	\$13.87

HB	18, 99	T2015	U2	Discovery and Career Planning	Employment	15 Minute	\$12.01
HB	18, 99	T2015	U1	BI Discovery and Career Planning	Employment	15 Minute	\$13.88
HB	18, 99	T2019	U2	Individual Employment Support, Job Development	Employment	15 Minute	\$11.45
HB	18, 99	T2019	U1	BI Individual Employment Support, Job Development	Employment	15 Minute	\$12.11
HB	18, 99	H2025	U2	Individual Employment Support, Job Coaching	Employment	15 Minute	\$10.63
HB	18, 99	H2025	U1	BI Individual Employment Support, Job Coaching	Employment	15 Minute	\$12.30
OH	12, 99	S5150		Respite Hourly, 1:1	Respite Care - Agency	15 Minute	\$5.65
OH	12, 99	T1005	U1	BI Respite Hourly, 1:1	Respite Care - Agency	15 Minute	\$5.84
OH	12, 99	S5150	UN	Respite Hourly, 1:2	Respite Care - Agency	15 Minute	\$3.14

OH	12, 99	T1005	UN	BI Respite Hourly, 1:2	Respite Care - Agency	15 Minute	\$3.24
OH	12, 99	S5150	UP	Respite Hourly, 1:3	Respite Care - Agency	15 Minute	\$2.31
OH	12, 99	T1005	UP	BI Respite Hourly, 1:3	Respite Care - Agency	15 Minute	\$2.38
OH	12, 99	T1002	22	Respite Daily, 1:1	Respite Care - Agency	Day	\$142.60
OH	12, 99	T1002	22	BI Respite Daily, 1:1	Respite Care - Agency	Day	\$142.60
CS	12	S5120	U2	Chore	Chore - Agency	15 Minute	\$5.82
CS	12	S5120	U1	BI Chore	Chore - Agency	15 Minute	\$6.52
AI	99	S0215	U2	Non-Medical Transportation	Non-Emergency Transportation	Mile	\$1.51
AI	99	S0215	U1	BI Non-Medical Transportation	Non-Emergency Transportation	Mile	\$1.70

PD	12, 99	T1002	TD	Skilled Nursing, Registered Nurse, 1:1	Nursing care in home by Registered Nurse	15 Minute	\$21.63
PD	12, 99	T1002		BI Skilled Nursing, Registered Nurse, 1:1	Nursing care in home by Registered Nurse	15 Minute	\$25.37
PD	12, 99	T1002	UN	Skilled Nursing, Registered Nurse, 1:2	Nursing care in home by Registered Nurse	15 Minute	\$11.35
PD	12, 99	T1002	U1	BI Skilled Nursing, Registered Nurse, 1:2	Nursing care in home by Registered Nurse	15 Minute	\$13.35
PD	12, 99	T1003	TE	Skilled Nursing, Licensed Practical Nurse, 1:1	Nursing care in home by Licensed Practical Nurse	15 Minute	\$12.68
PD	12, 99	T1003		BI Skilled Nursing, Licensed Practical Nurse, 1:1	Nursing care in home by Licensed Practical Nurse	15 Minute	\$15.52
PD	12, 99	T1003	UN	Skilled Nursing, Licensed Practical Nurse, 1:2	Nursing care in home by Licensed Practical Nurse	15 Minute	\$6.82
PD	12, 99	T1003	52	BI Skilled Nursing, Licensed Practical Nurse, 1:2	Nursing care in home by Licensed Practical Nurse	15 Minute	\$8.35

CT	11,12,14 33,49,99	98960	AE	Training and Consultation, Dietician	Training and Consultation, Dietician	Hour	\$59.08
CT	11,12,14 33,49,99	S5111	AE	BI Training and Consultation, Dietician	Training and Consultation, Dietician	Hour	\$70.42
CT	11,12,14 33,49,99	98960	U4	Training and Consultation, Dietician, Inter-Island	Training and Consultation, Dietician	Hour	\$162.31
CT	11,12,14 33,49,99	98960	U4	BI Training and Consultation, Dietician, Inter-Island	Training and Consultation, Dietician	Hour	\$162.31
CT	11,12,14 33,49,99	98960	AH	Training and Consultation, Psychologist	Training and Consultation, Psychologist	Hour	\$86.16
CT	11,12,14 33,49,99	S5111	AH	BI Training and Consultation, Psychologist	Training and Consultation, Psychologist	Hour	\$101.06

CT	11,12,14 33,49,99	98960	U5	Training and Consultation, Psychologist, Inter-Island	Training and Consultation, Psychologist	Hour	\$211.90
CT	11,12,14 33,49,99	98960	U5	BI Training and Consultation, Psychologist, Inter-Island	Training and Consultation, Psychologist	Hour	\$211.90
CT	11,12,14 33,49,99	98960	HI	Training and Consultation, Behavior	Training and Consultation, Behavior	Hour	\$86.16
CT	11,12,14 33,49,99	S5111	HI	BI Training and Consultation, Behavior	Training and Consultation, Behavior	Hour	\$101.06
CT	11,12,14 33,49,99	98960	U6	Training and Consultation, Behavior, Inter-Island	Training and Consultation, Behavior	Hour	\$211.90
CT	11,12,14 33,49,99	98960	U6	BI Training and Consultation, Behavior, Inter-Island	Training and Consultation, Behavior	Hour	\$211.90
CT	11,12,14 33,49,99	98960	GN	Training and Consultation, Speech	Training and Consultation, Speech	Hour	\$70.10

CT	11,12,14 33,49,99	S5111	GN	BI Training and Consultation, Speech	Training and Consultation, Speech	Hour	\$82.89
CT	11,12,14 33,49,99	98960	U7	Training and Consultation, Speech, Inter-Island	Training and Consultation, Speech	Hour	\$182.49
CT	11,12,14 33,49,99	98960	U7	BI Training and Consultation, Speech, Inter-Island	Training and Consultation, Speech	Hour	\$182.49
CT	12, 99	S9129	U2	Training and Consultation, Environmental Accessibility Adaptations	Training and Consultation, EAA	Hour	\$89.68
CT	12, 99	S9129	U1	BI Training and Consultation, Environmental Accessibility Adaptations	Training and Consultation, EAA	Hour	\$89.68

CT	12, 99	S9129	U3	Training and Consultation, Environmental Accessibility Adaptations, Inter-Island	Training and Consultation, EAA	Hour	\$182.49
CT	12, 99	S9129	U3	BI Training and Consultation, Environmental Accessibility Adaptations, Inter-Island	Training and Consultation, EAA	Hour	\$182.49
CT	11,12,14 33,49,99	98960	GO	Training and Consultation, OT	Training and Consultation, OT	Hour	\$70.10
CT	11,12,14 33,49,99	S5111	GO	BI Training and Consultation, OT	Training and Consultation, OT	Hour	\$82.89
CT	11,12,14 33,49,99	98960	U8	Training and Consultation, OT, Inter-Island	Training and Consultation, OT	Hour	\$182.49
CT	11,12,14 33,49,99	98960	U8	BI Training and Consultation, OT, Inter-Island	Training and Consultation, OT	Hour	\$182.49
CT	11,12,14 33,49,99	98960	GP	Training and Consultation, PT	Training and Consultation, PT	Hour	\$70.10
CT	11,12,14 33,49,99	S5111	GP	BI Training and Consultation, PT	Training and Consultation, PT	Hour	\$82.89

CT	11,12,14 33,49,99	98960	U9	Training and Consultation, PT, Inter-Island	Training and Consultation, PT	Hour	\$182.49
CT	11,12,14 33,49,99	98960	U9	BI Training and Consultation, PT, Inter-Island	Training and Consultation, PT	Hour	\$182.49
CT	11,12,14 33,49,99	98960	U1	Training and Consultation, Specialized Medical Equipment and Supplies	Training and Consultation, SME	Hour	\$70.10
CT	11,12,14 33,49,99	S5111	U1	BI Training and Consultation, Specialized Medical Equipment and Supplies	Training and Consultation, SME	Hour	\$82.89

CT	11,12,14 33,49,99	98960	UA	Training and Consultation, Specialized Medical Equipment and Supplies, Inter-Island	Training and Consultation, SME	Hour	\$182.49
CT	11,12,14 33,49,99	98960	UA	BI Training and Consultation, Specialized Medical Equipment and Supplies, Inter-Island	Training and Consultation, SME	Hour	\$182.49
CT	11,12,14 33,49,99	98960	U2	Training and Consultation, Assistive Technology	Training and Consultation, Assistive Technology	Hour	\$70.10
CT	11,12,14 33,49,99	S5111	U2	BI Training and Consultation, Assistive Technology	Training and Consultation, Assistive Technology	Hour	\$82.89
CT	11,12,14 33,49,99	98960	UB	Training and Consultation, Assistive Technology, Inter-Island	Training and Consultation, Assistive Technology	Hour	\$182.49
CT	11,12,14 33,49,99	98960	UB	BI Training and Consultation, Assistive Technology, Inter-Island	Training and Consultation, Assistive Technology	Hour	\$182.49
CT	11,12,14 33,49,99	98960	HO	Training and Consultation, Licensed, Marriage Family Therapist, Clinical Social Worker, Mental Health Counselor	Training and Consultation, LMFT/LCSW/LMHC	Hour	\$46.38
CT	11,12,14 33,49,99	S5111	HO	BI Training and Consultation, Licensed, Marriage Family Therapist, Clinical Social Worker, Mental Health Counselor	Training and Consultation, LMFT/LCSW/LMHC	Hour	\$56.07

CT	11,12,14 33,49,99	98960	UC	Training and Consultation, Licensed, Marriage Family Therapist, Clinical Social Worker, Mental Health Counselor, Inter-Island	Training and Consultation, LMFT/LCSW/LMHC	Hour	\$139.07
CT	11,12,14 33,49,99	98960	UC	BI Training and Consultation, Licensed, Marriage Family Therapist, Clinical Social Worker, Mental Health Counselor, Inter-Island	Training and Consultation, LMFT/LCSW/LMHC	Hour	\$139.07

CT	11,12,14 33,49,99	98960	TD	Training and Consultation, Registered Nurse	Training and Consultation, Registered Nurse	Hour	\$79.56
CT	11,12,14 33,49,99	S5111	TD	BI Training and Consultation, Registered Nurse	Training and Consultation, Registered Nurse	Hour	\$93.59
CT	11,12,14 33,49,99	98960	UD	Training and Consultation, Registered Nurse, Inter-Island	Training and Consultation, Registered Nurse	Hour	\$199.81
CT	11,12,14 33,49,99	98960	UD	BI Training and Consultation, Registered Nurse, Inter-Island	Training and Consultation, Registered Nurse	Hour	\$199.81
CI	12, 14, 18, 33, 99	T2034	U2	Waiver Emergency Services, Outreach	Crisis Intervention, Outreach	15 Minute	\$27.50
CI	12, 14, 18, 33, 99	T2034	U1	BI Waiver Emergency Services, Outreach	Crisis Intervention, Outreach	15 Minute	\$27.50
CI	14, 99	T2031	U2	Waiver Emergency Services, Shelter	Crisis Intervention, Outof-Home Stabilization	Day	\$499.23
CI	14, 99	T2031	U1	BI Waiver Emergency Services, Shelter	Crisis Intervention, Outof-Home Stabilization	Day	\$502.58
DU/EA	99	T2029	U1	Assistive Technology	Assistive Technology	Per Service Unit	\$1.00
DU/EA	99	T2029	U1	BI Assistive Technology	Assistive Technology	Per Service Unit	\$1.00
EA	99	S5165	U1	Environmental Accessibility Adaptations, Permits	Environmental Accessibility Adaptations, Permits	Per Service Unit	\$1.00

EA	99	S5165	U1	BI Environmental Accessibility Adaptations, Permits	Environmental Accessibility Adaptations, Permits	Per Service Unit	\$1.00
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EA	12	S5165		Environmental Accessibility Adaptations, Construction	Environmental Accessibility Adaptations, Construction	Per Service Unit	\$1.00
EA	12	S5165		BI Environmental Accessibility Adaptations, Construction	Environmental Accessibility Adaptations, Construction	Per Service Unit	\$1.00
EP/ER	12, 14, 33	S5160		Personal Emergency Response System, Installation	Personal Emergency Response System, Installation	Installation	\$65.00
EP/ER	12, 14, 33	S5160		BI Personal Emergency Response System, Installation	Personal Emergency Response System, Installation	Installation	\$65.00
EM/ER	12, 14, 33	S5161		Personal Emergency Response System, Service Fee, Per Month	Personal Emergency Response System, Service Fee, Per Month	Month	\$43.00
EM/ER	12, 14, 33	S5161		BI Personal Emergency Response System, Service Fee, Per Month	Personal Emergency Response System, Service Fee, Per Month	Month	\$43.00
DU/EA	99	T2029		Specialized Medical Equipment	Specialized Medical Equipment	Per Service Unit	\$1.00
DU/EA	99	T2029		BI Specialized Medical Equipment	Specialized Medical Equipment	Per Service Unit	\$1.00
SS/EA	99	T2028		Specialized Medical Supplies	Specialized Medical Supplies	Per Service Unit	\$1.00
SS/EA	99	T2028		BI Specialized Medical Supplies	Specialized Medical Supplies	Per Service Unit	\$1.00
VM	99	T2039		Vehicular Modifications	Vehicular Modifications	Per Service Unit	\$1.00
VM	99	T2039		BI Vehicular Modifications	Vehicular Modifications	Per Service Unit	\$1.00
Place of Service Codes:			(11) Office (12) Home (14) Group Home (18) Place of Employment/Worksite (33) Custodial Care Facility (49) Independent Clinic (99) Other unlisted fac				
BI = Big Island (codes and rates applicable to Island of Hawaii only)							
Rates are inclusive of all applicable taxes.							
Any and all expenditures and services to clients beyond the Department of Health case management authorization are subject to non-payment.							
Medicaid waiver services are not billable during periods of client hospitalization, long-term institutionalization or periods of suspension of the waiver.							

APPENDIX 14
WAIVER AMENDMENT
RESOURCES

APPENDIX 14A: HIGHLIGHTS OF POLICY CHANGES RELATED TO THE I/DD WAIVER AMENDMENT AND RATE STUDY

ADOPTION OF THE SUPPORTS INTENSITY SCALE (SIS) TO ASSIGN RATE TIERS

How is the system changing? The Supports Intensity Scale (SIS) will be used to assign participants to a level of need and a corresponding rate tier for certain services

Why is it changing?

- Provides a more **comprehensive assessment** of individual needs – the SIS evaluates a participant’s needs in a variety of areas: the supports they need for activities of daily living, assistance to function in the home or community, managing medical or behavioral issues, etc. rather than a narrower focus on nurse-delegated tasks and behavior support plans
- Increases **consistency across participants** – the SIS is a statistically validated instrument created by the American Association on Intellectual and Developmental Disabilities (AAIDD) that provides a consistent approach to assessments, ensuring that participants with similar needs are assigned to the appropriate level and have access to similar supports

What are the details of the changes?

- Tiered rates for **group-based services** – there are tiered rates for Residential Habilitation, Adult Day Health, and Community Learning Service-Group, with higher tiers paying for more intensive staffing and smaller group sizes
- **No tiered rates for PAB** – since it is primarily a one-to-one service, PAB will no longer have tiered rates
- **Three rate tiers** – for services with tiered rates, there will be three tiers: tier 1 includes those with the least needs (SIS-based levels 1 and 2), tier 2 includes those with moderate needs (SIS-based levels 3 and 4), and tier 3 includes those with the most significant needs (SIS-based levels 5, 6, and 7)
- **Standardization of staffing and supervision requirements** – the required qualifications for direct supports and supervisors will be the same across all rate tiers (for example, there will not be a requirement that any supervisor be a registered nurse)
- **Participants should *not* be grouped based on their rate tier** – a Residential Habilitation or ADH program may serve participants with different assigned levels in the same group and should not segregate individuals based on their levels; programs should be designed around participants’ individual goals and needs
- **Three-year assessment cycle** – in order to spread the assessments out, participants have been divided into three ‘cohorts’: individuals receiving Residential Habilitation services will receive a SIS before their ISP in fiscal year 2018, individuals who do not receive Residential Habilitation but do receive Adult Day Health will be assessed in fiscal year 2019, and

everyone else will be assessed in fiscal year 2020; participants will be reassessed approximately every three years

BIG ISLAND RATES

How is the system changing? There will be two fee schedules: one for services delivered on the Big Island and another for services delivered on all other islands.

Why is it changing? On average, providers must **travel longer distances** to provide services on the Big Island so the rates reflect this higher cost; rates for services on the other islands account for more traffic congestion and Oahu's higher general excise tax.

CREATION OF REGISTERED BEHAVIOR TECHNICIAN (RBT) RATES

How is the system changing? Higher rates are being established for services delivered by RBTs

Why is it changing?

- Supports participants with significant behavioral needs who can benefit from the **specialized expertise of registered behavior technicians** who have more training and are paid more than direct support professionals (which necessitates higher rates)
- **Complies with recent laws** regarding behavioral supports

What are the details of the changes? RBT rates have been established for **PAB and Community Learning Service-Individual**

ELIMINATION OF DAILY RATES FOR PAB AND RESPITE

How is the system changing? With one exception, daily rates for PAB and Respite services are being eliminated, requiring that these services be billed in 15-minute increments

Why is it changing?

- Increases the **fairness** of the rates – providers will be paid for the amount of service they provide rather than a 'one-size-fits-all' rate that is the same regardless of whether 12, 18, or 24 hours of service are provided

- Ensures **compliance with labor laws** – 15 minute billing allows for the tracking of the hours of service that a direct support professional provides so that these staff can be paid for each hour that they work (consistent with the provider billing by the hour)

What are the details of the changes? With the exception of Respite services provided in a licensed or certified home, **daily rates for these services are being eliminated**

EXPANSION OF AND CHANGES TO CONSUMER-DIRECTED SERVICES

How is the system changing? A consumer-directed option is being added to more services and additional flexibility is being added to service rates

Why is it changing? A significant portion of waiver services are already consumer-directed, which support individual choice and self-determination; the changes build on this success while ensuring **compliance with federal and state labor laws**

What are the details of the changes?

- **More services** with a consumer-directed option – in addition to PAB, Respite, and Chore services, participants will be able to direct Transportation as well as the new Community Learning Support Individual service (effectively PAB in the community)
- Creation of a ‘**rate range**’ – rather than a single, fixed rate, there is a range of permissible rates that participants (in their role as employers) may negotiate with their workers
- **Elimination of daily Respite** – as noted above, most daily rates – including consumer-directed Respite – are being eliminated

REESTABLISHMENT OF RESIDENTIAL HABILITATION

How is the system changing? PAB services delivered in a licensed or certified setting will be shifted to Residential Habilitation (which is being added back into the waiver; it had been covered as PAB over the past five years)

Why is it changing?

- Recognizes that this is a **full-time service** – participants receive support throughout the day and not only for a few hours
- Enhances **consistency in provider payments** based on participants’ needs – tiered rates ensure participants with similar assessed needs will have access to similar levels of support – rather than current hourly authorizations that vary substantially
- Allows for the creation of **rates that vary based on home size** – higher rates for smaller homes ensure that these settings can be financially viable

- **Accounts for all service costs** in the rate – eliminating the need for General Fund dollars to subsidize waiver costs

What are the details of the changes?

- **Varied rates** – rates vary based on the size of the home (its licensed capacity) and the needs of the individual participant based on their assessed needs (as determined by the SIS); there is also a different rate for therapeutic living programs
- **Daily units** – services are paid using daily rates
- **‘Paying for’ absences** – the rates are based on a 344-day billing year, effectively spread the cost of 21 absences over these 344 days; providers therefore will be limited to 344 days per plan year
(since they will have been paid for 365 days of service over the 344 billing days)
- Access to **additional services** – a new service, Additional Residential Supports, can be requested for participants need more support than assumed in the Residential Habilitation rate model; additionally, providers will be able to bill for Skilled Nursing and Training & Consultation services provided to individuals receiving Residential Habilitation
- **Elimination of DD domiciliary subsidies** – overall increase in waiver rates allow for the elimination of the General Fund payments that are paid to some providers to subsidize waiver service costs

CREATION OF COMMUNITY LEARNING SERVICE

How is the system changing? A new service – Community Learning Service (CLS) – has been created for PAB and ADH services provided in the community

Why is it changing?

- Recognizes **higher costs for community-based services** – the CLS rates are higher than the corresponding PAB and ADH rates to reflect providers’ higher costs and ensure that these costs are not a barrier to community-based services
- Supports **compliance with the home and community based service rule** – the creation of a separate service for community-based services both provides adequate payment for these services (as noted above) and allows for the tracking of services provided outside of the home or a center

What are the details of the changes?

- **Community component** of PAB and ADH programs – existing PAB and ADH services delivered in the community will be shifted to CLS with billing to reflect where the service is delivered; for example, if a provider delivers four hours of service in a participant’s home and then two hours in the community, they would bill four hours of PAB and two hours of

CLS-Individual (although CLS does not need to be attached to PAB or ADH; that is, a participant may receive CLS without receive PAB or ADH)

- **Individual and tiered group rates** – CLS has rates for one-to-one services and for group services, which are tiered based on a participant’s assigned level of need (with higher rates for those assigned to the higher levels in order to support more intensive staffing)
- **Group size limitation** – CLS-Group services are limited to three participants per direct support worker
- **Annual limit** for group services – participants will be able to access up to 1,560 hours of CLSGroup and ADH in total

OTHER CHANGES TO PERSONAL ASSISTANCE/ HABILITATION (PAB) SERVICES

How is the system changing? In addition to the elimination of rate tiers, the conversion of services in licensed and certified setting to Residential Habilitation, and the creation of CLS-Individual for services provided in the community, other changes are being made to PAB standards

Why is it changing? Updated requirements modernize the service and make it **more flexible** for providers and participants

What are the details of the changes?

- Creation of rates for ‘**group**’ services – although PAB is primarily a one-to-one service, there may be instances when one direct support professional may support multiple participants (for example, two siblings who live together and receive waiver services)
- **Eliminate four-staff rates** – there are times when a participant’s needs are so significant that they require two or three direct support professionals to manage them, but a four-staff rate is not necessary

OTHER CHANGES TO ADULT DAY HEALTH SERVICES

How is the system changing? In addition to the adoption of the SIS to determine rate tiers and the creation of CLS-Group for services provided in the community, several other changes are being made to ADH standards

Why is it changing? Updated requirements modernize the service and make it **more flexible** for providers and participants

What are the details of the changes?

- **15-minute billing** – daily rates are being replaced with 15-minute units so that providers are paid for the services that they deliver and to allow billing for both ADH and CLS-Group during the same day
- **Group size limitation** – ADH services are limited to six participants per direct support worker (as previously noted, CLS-Group services are limited to three participants per worker)
- **Annual limit** – participants will be able to access up to 1,560 hours of CLS-Group and ADH in total
- **Elimination of lunch requirement** – providers will no longer be required to provide lunch so that participants have more options and programs are not ‘designed around’ lunch (providers will be able to offer a meal at a reasonable cost, but cannot make purchase of a meal a condition of attending the program)

OTHER CHANGES TO RESPITE SERVICES

How is the system changing? In addition to the elimination of the daily rate, several other changes are being made to Respite standards

Why is it changing? Updated requirements **modernize** the service

What are the details of the changes?

- Creation of rates for ‘**group**’ services – although Respite is primarily a one-to-one service, there may be instances when one direct support professional may support multiple participants (for example, two siblings who live together and receive waiver services)
- Establishment of an **annual limit** – participants will be limited to 760 hours (more than 31 full days) of service per year

EMPLOYMENT SERVICES

How is the system changing? Existing employment services are being ‘broken out’ into components and new services are being added

Why is it changing?

- Recognizes that employment services include a **continuum of supports** – various activities require different expertise and otherwise have different costs
- **Tracking and monitoring** services – the establishment of different services with different rates and billing codes will provide more information about the extent to which participants are involved in employment activities and at what stages

What are the details of the changes?

- Prevocational services become **Discovery & Career Planning** – allows participants to explore their employment-related interests and engage in other career planning activities such as volunteering or working on interviewing skills
 - Creation of new **Benefits Planning** service (which is technically covered as part of the Discovery and Career Planning waiver service) – allows participants to work with benefits counselors to determine the impact of employment on federal Social Security benefits
 - Division of Individual Employment Support into **Job Development and Job Coaching** – helps participants to *obtain* a job (Job Development) and to *retain* a job (Job Coaching)
-

OTHER CHANGES TO NURSING AND TRAINING & CONSULTATION SERVICES

How is the system changing? In addition to allowing these services to be billed for supports provided in residential environments, several other changes are being made to Nursing and Training & Consultation standards

Why is it changing? Updated requirements modernize and **improve access** to these services

What are the details of the changes?

- Creation of rates for ‘**group**’ **services for Nursing** – although the service is primarily delivered one-to-one, there may be (very rare) instances when one nurse may support two participants (for example, two siblings who live together and receive waiver services)
 - **Addition and elimination of certain covered professionals** for Training & Consultation – codes are being added for registered nurses and licensed social workers (LCSW, LMHC, and LMFT) while codes are being eliminated for psychiatrist and audiologists
-

APPENDIX 14B: PHASE-IN TIMING FOR NEW RATES, BY SERVICES AND ‘COHORT’ PREPARED FOR DEVELOPMENTAL DISABILITIES DIVISION

Phase-In Timing for New Rates, by Services and ‘Cohort’ prepared for Developmental Disabilities Division

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change (unless noted)</i>	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)
<i>Service</i>				
<i>Agency Personal Assistance/ Habilitation (to be limited to in-home services) (includes RBT services)</i>		Transition to daily Residential Habilitation rates based on ISP date. (use of PAB ends for this group based on ISP date)	Remains on tiered rates in year 1. Transition to new fee schedule (without tiered rates) based on ISP date in year 2.	Remains on tiered rates in years 1 and 2. Transition to new fee schedule (without tiered rates) based on ISP date in year 3.
<i>Agency Community Learning Service – Individual (formerly PAB delivered in the community) (includes RBT services)</i>	Available to everyone based on ISP date.	(see all participants)	(see all participants)	(see all participants)
<i>Residential Habilitation (including Therapeutic Living Program)</i>		Transition from PAB to daily Residential Habilitation rates based on ISP date.	N/A	N/A
<i>Additional Residential Supports</i>		Becomes available with Residential Habilitation based on ISP date	N/A	N/A

Burns & Associates, Inc.

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March 27, 2017

Phase-In Timing for New Rates, by Services and 'Cohort'
prepared for Developmental Disabilities Division

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change (unless noted)</i>	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)

<i>Service</i>				
Adult Day Health	Transition to new fee schedule using 15-minute billing based on ISP date. (limited to center-based services) (Daily and half-day rates phase out based on ISP date)	Assigned to Tier that corresponds to their SIS-based level in year 1.	Assigned to current ADH Tier in year 1. Assigned to Tier that corresponds to their SIS-based level in year 2 based on ISP date.	N/A (although participants could choose to begin participating in an ADH program)
Community Learning Service – Group	Available to everyone based on ISP date. (formerly ADH in the community but does not have to be attached to an ADH program)	Assigned to Tier that corresponds to their SIS-based level in year 1.	Assigned to Tier that corresponds to current ADH Tier in year 1. Assigned to Tier that corresponds to their SIS-based level in year 2 based on ISP date.	N/A (although participants could choose to begin participating in a CLS-Group program)
Discovery and Career Planning	Available to everyone based on ISP date. (Prevocational phases out based on ISP date)	(see all participants)	(see all participants)	(see all participants)
Benefit Planning	Available to everyone based on ISP date. (Prevocational phases out based on ISP date)	(see all participants)	(see all participants)	(see all participants)

Phase-In Timing for New Rates, by Services and 'Cohort'
prepared for Developmental Disabilities Division

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change (unless noted)</i>	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)

<i>Service</i>		(see all participants)	(see all participants)	(see all participants)
Individual Employment Support – Job Development	Available to everyone based on ISP date. (Current Employment service phases out based on ISP date)	(see all participants)	(see all participants)	(see all participants)
Individual Employment Support – Job Coaching	Available to everyone based on ISP date. (Current Employment service phases out based on ISP date)	(see all participants)	(see all participants)	(see all participants)
Respite Hourly – Agency	Available to everyone based on ISP date.	N/A	(see all participants)	(see all participants)
Respite Daily – Agency	Available to everyone based on ISP date Limitation to use in a licensed or certified home phases in.	N/A	(see all participants)	(see all participants)
Chore – Agency (Rate change only)	Available to everyone based on ISP date	N/A	(see all participants)	(see all participants)

**Phase-In Timing for New Rates, by Services and ‘Cohort’
prepared for Developmental Disabilities Division**

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change</i> (unless noted)	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)

<i>Service</i>		(see all participants)	(see all participants)	(see all participants)
Non-Medical Transportation (Rate change only)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
Skilled Nursing (Rate change only)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
Training and Consultation	Available to everyone based on ISP date Psychiatrist and audiologist phases out Registered Nurse and LCSW/ LMHC/ LMFT phases in	(see all participants)	(see all participants)	(see all participants)
Assistive Technology (no changes)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
Environmental Accessibility Adaptations (no changes)	Available to everyone based on ISP date	N/A	(see all participants)	(see all participants)

**Phase-In Timing for New Rates, by Services and ‘Cohort’
prepared for Developmental Disabilities Division**

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change</i> (unless noted)	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)

<i>Service</i>		(see all participants)	(see all participants)	(see all participants)
Personal Emergency Response System (no changes)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
Specialized Medical Equipment and Supplies (no changes)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
Vehicle Modifications (no changes)	Available to everyone based on ISP date	N/A	(see all participants)	(see all participants)
Waiver Emergency Services (no changes)	Available to everyone based on ISP date	(see all participants)	(see all participants)	(see all participants)
<i>Consumer-Directed Services</i>				
Personal Assistance/ Habilitation <i>Consumer Directed</i> (to be limited to in-home)	New rate available to everyone using consumer-direction based on ISP date	N/A	(see all participants)	(see all participants)

**Phase-In Timing for New Rates, by Services and ‘Cohort’
prepared for Developmental Disabilities Division**

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change (unless noted)</i>	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)

<i>Service</i>		(see all participants)	(see all participants)	(see all participants)
Community Learning Service – Individual <i>Consumer Directed</i> (formerly PAB delivered in the community)	Available to everyone using consumer-direction based on ISP date			
Respite Hourly <i>Consumer-Directed</i>	Available to everyone using consumer-direction based on ISP date	N/A	(see all participants)	(see all participants)
Respite Daily <i>Consumer-Directed</i>	Existing rate remains available to everyone using consumer-direction in the first year until ISP date (Consumer-directed Respite Daily phases out based on ISP date.) (Limitation to use in a licensed or certified home phases in.)	N/A	(see all participants)	(see all participants)

**Phase-In Timing for New Rates, by Services and ‘Cohort’
prepared for Developmental Disabilities Division**

<i>Population Group</i>	<i>All Participants</i>	<i>Cohort 1</i> (Participants residing in certified or licensed settings)	<i>Cohort 2</i> (Participants living independently, in family homes, or unlicensed settings AND receiving Adult Day Health)	<i>Cohort 3</i> (Participants living independently, in family homes, or unlicensed settings and NOT receiving Adult Day Health)
<i>Date of Change</i> (unless noted)	July 1, 2017 – June 30, 2018	July 1, 2017 – June 30, 2018 (Year 1)	July 1, 2018 – June 30, 2019 (Year 2)	July 1, 2019 – June 30, 2020 (Year 3)
<i>Service</i>				
Chore <i>Consumer Directed</i> (Rate change only))	Available to everyone using consumer-direction based on ISP date	N/A	(see all participants)	(see all participants)
Non-Medical Transportation – <i>Consumer-Directed</i> (Rate change only)	Available to everyone using consumer-direction based on ISP date	(see all participants)	(see all participants)	(see all participants)

APPENDIX 15
HYPERLINKS TO
HAWAII ADMINISTRATIVE RULES (HAR)

HYPERLINKS TO HAWAII ADMINISTRATIVE RULES (HAR)

HAR Title 11 Department of Health Chapter 148

“Certification of Adult Foster Homes”

<http://health.hawaii.gov/opppd/files/2015/06/11-148.pdf>

HAR Title 11 Department of Health Chapter 100.1

“Adult Residential Care Homes”

<http://health.hawaii.gov/opppd/files/2015/06/11-100.1.pdf>

HAR Title 11 Department of Health Chapter 89

“Developmental Disabilities Domiciliary Homes”

<http://health.hawaii.gov/opppd/files/2015/06/11-89.pdf>

HAR Title 11 Department of Health Chapter 98

“Special Treatment Facility”

<http://health.hawaii.gov/opppd/files/2015/06/11-98.pdf>